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C. R.—Case Report (Clinical Notes).
Ed.—Editorial.
E. C.—Editorial Comment.

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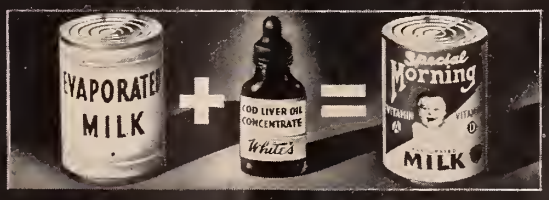

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Editor—George H. Kress, 450 Sutter Street, Room 2004, San Francisco.

Executive Secretary—John Hunton, 450 Sutter Street, Room 2004, San Francisco.

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Second District—Los Angeles County, George D. Maner (1942), 657 South Westlake Avenue, Los Angeles.

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Fourth District—Calaveras, Fresno, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tulare and Tuolumne Counties, Axcel E. Anderson (1944), Medical Group Building, 1759 Fulton Street, Fresno.

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Sixth District—San Francisco County, John W. Cline (1943), 1020 Medico-Dental Building, 490 Post Street, San Francisco.

Seventh District—Alameda and Contra Costa Counties, Frank R. Makinson (1944), 426 Seventeenth Street, Oakland.

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Ninth District—Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma and Trinity Counties, John W. Green (1943), Box 539, Vallejo.

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Elbridge J. Best (1942), 384 Post Street, San Francisco.

Dewey R. Powell (1943), Room 501, 242 No. Sutter Street, Stockton.

Edward B. Dewey (1943), Professional Building, 65 No. Madison Avenue, Pasadena.

Philip K. Gilman (1944), 2000 Van Ness Avenue, San Francisco.

E. Earl Moody (1944), 829 South Alvarado Street, Los Angeles.

Standing Committees

Executive Committee

The President, the President-Elect, the Speaker of the House of Delegates, the Chairman of the Council, the Chairman of the Auditing Committee, the Past President, the Secretary-Treasurer (ex officio), and the Editor (ex officio).

Auditing Committee

Elbridge J. Best (Chairman)	San Francisco	1942
John W. Cline	San Francisco	1942
Frank R. Makinson	Oakland	1942

Members of the Auditing Committee are appointed each year by the Chairman of the Council.

Committee on Associated Societies and Technical Groups

Walter H. Newman	San Diego	1942
John V. Barrows (Chairman)	Los Angeles	1943
Edwin L. Bruck	San Francisco	1944

Committee on Health and Public Instruction

Wilton Halverson	Pasadena	1942
J. C. Geiger	San Francisco	1943
John Ruddock (Chairman)	Los Angeles	1944

Committee on History and Obituaries

J. Marion Read	San Francisco	1942
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Morton Gibbons (Chairman)	San Francisco	1944

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Donald Cass (Chairman)	Los Angeles	1942
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Committee on Medical Defense

William J. Van Den Berg	Sacramento	1942
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L. R. Chandler (Chairman)	San Francisco	1942
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Committee on Postgraduate Activities

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Dwight L. Wilbur (Chairman)	San Francisco	1943
F. E. Clough (Vice-Chairman, So. Calif.)	San Bernardino	1944

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Committee on Public Policy and Legislation

Authony Diepenbrock	San Francisco	1942
E. T. Remmen	Los Angeles	1943
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Fletcher B. Taylor	Oakland	1943
J. Homer Woolsey	Woodland	1944

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Communications for the Public Relations Department should be addressed to the Director, Mr. John Hunton, Room 2004, 450 Sutter Street, San Francisco.

Cancer Commission

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Charles A. Dukes (Chairman)	Oakland	1943
Lyell E. Kinney (Vice-Chairman)	San Diego	1943
Otto H. Pflueger (Secretary)	San Francisco	1943
Orville N. Meland	Los Angeles	1944
A. Herman Zeiler	Los Angeles	1944
Gertrude Moore	Oakland	1944

Communications for the Cancer Commission should be addressed to the Secretary, Otto H. Pflueger, M. D., 384 Post Street, San Francisco.

(Roster lists of officers of scientific sections, component county societies, Woman's Auxiliary, A. M. A. delegates, special committees, etc., are continued on advertising pages 4 and 6.)

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(Continued on Page 5)

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ROSTER OF COUNTY MEDICAL SOCIETIES, CALIFORNIA MEDICAL ASSOCIATION

(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association

2404 Broadway, Oakland

President, John W. Sherrick, 350 Twenty-ninth Street, Oakland.
Secretary, Gertrude Moore, 353 30th Street, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn County Medical Society

President, Charles Benninger, Jr., Oroville.
Secretary, J. O. Chiapella, 131 Broauway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society

President, R. J. P. Harmon, 314 Tenth Street, Richmond.
Secretary, L. Abbott Hedges, 912 Macdonald Avenue, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society

President, Frank R. Ruff, 1234 S Street, Fresno.
Secretary, J. E. Young, 405 Rowell Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society

President, Lowell G. Kramar, 1049 Main Street, Fortuna.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society

President, William A. Clarke, 132 Fifth Street, Holtville.
Secretary, Claude F. Peters, 722 Main Street, El Centro.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society

President, H. W. Crook, 106 S. Main, Bishop.
Secretary, George Shultz, 124 N. Main, Lone Pine.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society

President, Lucille B. May, 1706 Chester Ave., Bakersfield.
Secretary, Sophie M. Loven, 458 Haherfelde Building, Bakersfield.
Meeting, *Third Thursday, 8:00 p. m.*

Kings County Medical Society

President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, Arthur Zeismer, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society

President, W. B. McKnight, Portola.
Secretary, Bernard S. Holm, Quincy.
Meeting, *On Call.*

Los Angeles County Medical Association

1925 Wilshire Boulevard, Los Angeles

President, Thomas C. Myers, 1501 So. Figueroa Street, Los Angeles.
Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society

President, Wilson P. Goddard, 308 Throckmorton Street, Mill Valley.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, Deer Park Villa, Fairfax.*

Mendocino-Lake County Medical Society

President, Royal Scudder, 123 Laurel Street, Fort Bragg.
Secretary, Otto L. Gericke, Mendocino State Hospital, Talmage.
Meeting, *on Call.*

Merced County Medical Society

President, A. B. Bigler, 165 N. Second Street, Chowchilla.
Secretary, James A. Parker, Bank of America Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society

President, James McPharlin, 8 East Alisal Street, Salinas.
Secretary, R. D. Mace, 601 South Main Street, Salinas.
Meeting, *First Thursday.*

Napa County Medical Society

President, R. C. Burkett, 1130 First Street, Napa.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association

President, Lawrence C. Cameron, 218 South Main Street, Santa Ana.
Secretary, Milo K. Tedstrom, 1626 Bush Street, Santa Ana.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society

President, Lucas W. Empey, Roseville.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society

President, Wayne K. Templeton, 3770 Twelfth Street, Riverside.
Secretary, Hobart M. Kelly, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement

President, Frank Warne Lee, 510 Physicians Building, Sacramento.
Secretary, Curtis H. McDonnell, California State Life Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society

President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society

President, Eugene H. Hull, San Bernardino.
Secretary, A. E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society

1410 Medico-Dental Building, 233 A Street, San Diego

President, Frank A. St. Sure, 4067 Van Dyke Avenue, San Diego.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society

2180 Washington Street, San Francisco

President, Harold A. Fletcher, 490 Post Street, San Francisco.
Secretary, L. Henry Garland, 2180 Washington Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society

President, Raymond Leroy Owens, 28 Cory Building, Lodi.
Secretary, George H. Rohrbacher, 1005 Medico-Dental Building, Stockton
Acting Secretary, C. A. Broaddus, 242 North Sutter Street, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society

President, Horace Hagan, 1215 Chorro Street, San Luis Obispo.
Secretary, E. M. Bingham, County Health Department, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society

President, H. H. Whitney, 1204 Burlingame Avenue, Burlingame.
Secretary, Thomas Farthing, 23 Second Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barhara County Medical Society

President, H. R. Schwalenberg, Cottage Hospital, Santa Barhara.
Secretary, D. H. McNamara, 317 W. Puehlo Street, Santa Barhara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society

President, A. J. Baiocchi, 369 South Third Street, San Jose.
Secretary, Leon P. Fox, Ste. Claire Building, San Jose.
Meeting, *Third Monday, 7:00 p. m., Sainte Claire Hotel, San Jose.*

Santa Cruz County Medical Society

President, Avery Wood, 335 Main Street, Watsonville.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meeting, *First Tuesday of each month (except June, July and August), 7:30 p. m., Club Rio del Mar, Aptos.*

Shasta County Medical Society

President, Earnest Dozier, Redding.
Secretary, Julius M. Kehoe, Redding.
Meeting, *Second Monday.*

Siskiyou County Medical Society

President, F. W. Martin, 106 Orem Street, Mt. Shasta.
Secretary, Victor W. Hart, 113 No. Oregon Street, Yreka.
Meeting, *Sunday on call.*

Solano County Medical Society

President, Gordon Bunney, Suisun.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Tuesday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society

President, Leighton Ray, 536 B Street, Santa Rosa.
Secretary, J. F. Thurlow, 576 B Street, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society

President, Hoyt R. Gant, 1024 J Street, Modesto.
Secretary, A. E. Ghilotti, 1024 J Street, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society

President, R. G. Frey, Red Bluff.
Secretary, F. J. Bailey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society

President, Ray E. Cronemiller, 160 South E Street, Exeter.
Secretary, Forrest G. Powell, 222 W. Willow Street, Visalia.
Meeting, *Sunday Evening once a month*

Ventura County Medical Society

President, James W. Moore, 23 S. California Street, Ventura.
Secretary, Robert K. Harker, 132 Fourth Street, Oxnard.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society

President, Edwin K. Copeland, 405 First Street, Woodland.
Secretary, Wilfred T. Rohbins, 719 Second Street, Davis.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society

President, Romayne B. Whitney, Plumas Street, Yuba City.
Secretary, Leon M. Swift, I. O. O. F. Building, Marysville.
Meeting, *Second Wednesday.*

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(Continued from Page 3)

California Packet Library Services

In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of Caliiornia may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco.

Barlow Medical Library (Los Angeles County Medical Association), 634 South Westlake, Los Angeles.

Nonprofit Hospitalization Corporations

In California, the three nonprofit hospitalization corporations named below are in operation:

Hospital Service of California, 333 Pine Street, San Francisco; 675 East Santa Clara, San Jose; 364 Fourteenth Street, Oakland.

Associated Hospital Service of Southern California, 1151 South Broadway, Los Angeles.

Intercoast Hospitalization Insurance Association, 1127 "J" Street, Sacramento.

OFFICERS OF SCIENTIFIC SECTIONS, CALIFORNIA MEDICAL ASSOCIATION

Request is made that any member who desires to submit papers before an annual session section, write in regard thereto, to respective section secretary, as soon as convenient after the close of an annual session.

Anesthesiology

Chairman, Charles F. McCuskey, 1561 Puebla Drive, Glendale.
Secretary, Karolina B. Jump, Mills Memorial Hospital, San Mateo.

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Vice-Chairman, Herman V. Allington, 3115 Webster Street, Oakland.
Secretary, Thomas Walker Nisbet, 65 North Madison Avenue, Pasadena.

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Vice-Chairman, George McClure, 411 Thirtieth Street, Oakland.
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Vice-Chairman, Wilhur J. Cox, 450 Sutter Street, San Francisco.
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William R. Molony, Sr., Los Angeles	(1941-1942)	John C. Ruddock, Los Angeles
Elbridge J. Best, San Francisco	(1942-1943)	L. R. Chandler, San Francisco
Lyell C. Kinney, San Diego	(1942-1943)	Bon O. Adams, Riverside
Harry H. Wilson, Los Angeles	(1942-1943)	Roy E. Thomas, Los Angeles
Henry S. Rogers, Petaluma	(1942-1943)	Philip K. Gilman, San Francisco

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1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," Am. J. Syph., Gon. & Ven. Dis., **23**, 201 (March), 1939.

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TWENTY-FIVE YEARS AGO

(Continued from Text Page 54)

The House of Delegates, at the Fresno meeting, requested the Council to arrange a plan by which the members who desire to do so could contribute to a fund out of which charges of this kind against such members could be paid. This has been done, and the plan, as outlined and approved by the Council, and prepared by its attorneys, is published herewith. (See infra.)

* * *

Safety at Reasonable Cost.—It will be seen from the plan presented under the heading, "Malpractice Indemnity Fund," that any or all of our members may thoroughly protect themselves against possible judgments at a cost very much less than the amount paid to an insurance company. Even if there were a great many judgments, and even if the amount of them required a payment to the fund of $15 as frequently as every other year, there would be a saving of at least 50 per cent to each member participating in this enterprise. It is probable that if between 500 and 1,000 members will take advantage of this offer, they will not have to pay an assessment more often than, at the most, once in five years, though of course this is merely surmise.

The reason why a promissory note for $15, made payable one year after date, is required, is that the fund may be assured of the two successive years' contribution by every member participating, and thus avoid the difficulties and complications which would arise by a member paying one year and not the second.

* * *

Malpractice Indemnity Fund.—The House of Delegates of the Medical Society of the State of California, at its

(Continued on Next Page)

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

forty-fifth annual session, Fresno, California, April 19, 1916, passed a resolution requesting the Council of the Medical Society of the State of California to take proper and appropriate action to the end that means may be provided whereby members of the Medical Society of the State of California who desire to do so may voluntarily contribute to a fund, out of which fund shall be paid the amount of judgments assessed against such contributing members in any suit or suits against such contributing members for damages for alleged malpractice, and also payment of such sums as may be necessary for the settlement of claims against such contributing members when, in the judgment of competent and experienced attorneys, by and with the concurrence of the attorneys for the Medical Society of the State of California, and by and with the

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consent and concurrence of such contributing member, it seems wise and expedient to settle such claim or claims and the necessary expenses connected therewith.

The Council, having considered this matter, and having referred the same to its attorneys who have considered, amended and revised this statement or plan of conduct of this undertaking, presents the following detailed plan for the conduct and operation of this indemnity fund: . . .

* * *

Not Only Surgeons.—A good many men in general practice have the idea that only surgeons, or almost exclusively surgeons, are subject to suits for damages for alleged malpractice, for the reason that such suits—in their opinion—always originate out of fractures or similar injuries. This is not the case. Some of the worst suits that we have had in the past, and have now on hand to defend, have been suits brought against physician members in the ordinary course of general practice, confinement work and the like. One bitterly fought suit had its origin in the question of correct diagnosis of tuberculosis. Another one, lasting two weeks or more in trial, originated in a confinement case. Still another had its origin in the examination of school pupils. There is no limit to the possible range of conditions or treatments out of which a suit for damages may arise.

* * *

The Harrison Narcotic Law.—In the first place, let it be said that the purpose and intent of the law are beyond all question of the greatest benefit to society, to physicians, and to persons who come to physicians as patients. There are, however, numerous things about it that are vexatious. Some of the rules made are absurd, and it would be practically impossible for any physician actively to practice his profession and not violate some of these rules and regu-

(Continued on Next Page)

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

lations. For instance, in the matter of absurdity, Treasury decision 2213 learnedly lays down the rule that a physician's prescription, when made up, is a preparation and not a remedy. One is reminded of many wise questions that have been propounded; as, for instance, "Why is a red-hot stove?" It is also somewhat annoying to see incompetent and unfitted persons on the pay roll of the Government making silly and bothersome rules of this kind, and at the same time read from the court report in a newspaper that a man running a regular business in selling narcotics to drug fiends, when arrested, was penalized only to the extent of thirty days in the county jail. Physicians, as a class, are doing a great deal, by conforming willingly to the Harrison Law, toward the end of suppressing the habit-forming drug evil. However, if society wishes to rid itself of this pest, it will have to coöperate with physicians in future more than it has in the past.

* * *

A Business Proposition.—Remember that the business side of the work of the State Society has now attained remarkable proportions; nearly all of the work passing through the office of the Society is business of a non-medical character. . . .

* * *

Health Insurance.—The medical aspect of health insurance will soon attain the same importance here that it has already attained in New York, where a health insurance bill was presented to the legislature of the past winter. There, the bill introduced without hope of passage the first year, did not contain detailed provisions for the

(Continued on Page 26)

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Measuring Treatment of Bone Tumors.—The effect of the treatment of some types of bone tumors with radium or radio-active substances may be determined by measurements of phosphatase in the blood serum, Helen Q. Woodard, Ph. D., and Norman L. Higinbotham, M. D., New York, report in *The Journal of the American Medical Association.*

This is possible, they explain, because some bone tumors produce phosphatase, which enters the circulation and can be measured in the blood serum. The phosphatase-producing mechanism of most of these tumors is inactivated by radiation treatment when the tissue dose equals or exceeds 4,000 roentgens. Smaller doses cause only irregular or incomplete inactivation.

Their report is particularly significant because of the recent announcement that phosphorus can be made radioactive for use in treating bone diseases by means of the cyclotron or atom smashing machine. Radio-active phosphorus given by mouth, the two New Yorkers explain, localizes in the portions of bone tumor tissue which contain the most phosphatase.

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BOOK REVIEWS

Manual of Physical Diagnosis, with Special Consideration of the Heart and Lungs. By Maurice Lewison, M. D., Professor of Physical Diagnosis, University of Illinois College of Medicine; Consulting Physician, Cook County Hospital; Attending Physician, Mount Sinai Hospital, Chicago; Formerly Attending Physician and Chief of Tuberculosis Staff, Cook County Hospital. And Ellis B. Freilich, M. D., Associate Professor of Medicine, University of Illinois College of Medicine; Professor of Medicine, Cook County Graduate School of Medicine; Attending Physician and Chief of Tuberculosis Staff, Cook County Hospital; Consultant to the Chicago Municipal Tuberculosis Sanitarium; Attending Physician, University Hospital; Associate Attending Physician, Mount Sinai Hospital, Chicago. In collaboration with George C. Coe, M. D., Instructor of Medicine, University of Illinois College of Medicine; Associate Physician, Cook County Hospital; Clinical Assistant, Mount Sinai Hospital, Chicago. Cloth. Pp. 317. Chicago, Illinois: The Year Book Publishers, Inc.

In this volume the authors discuss physical diagnosis under four sections: History and General Examination, The Respiratory System, The Cardiovascular System, and The Abdomen, Genitalia, Extremities, and Reflexes. The descriptions are concise and well correlated with photographs, line drawings, and reproductions of x-rays. In the section on the heart and lungs, an especially lucid method of procedure is outlined to elicit the various lesions. The index seems somewhat incomplete, but is adequate for a volume probably intended as a student's handbook.—J. H. A.

BOOKS RECEIVED

The Therapeutics of Internal Diseases. Volume III. Edited by George Blumer, M. A. (Yale), M. D., David P. Smith, Clinical Professor of Medicine, Yale University

(Continued on Page 16)

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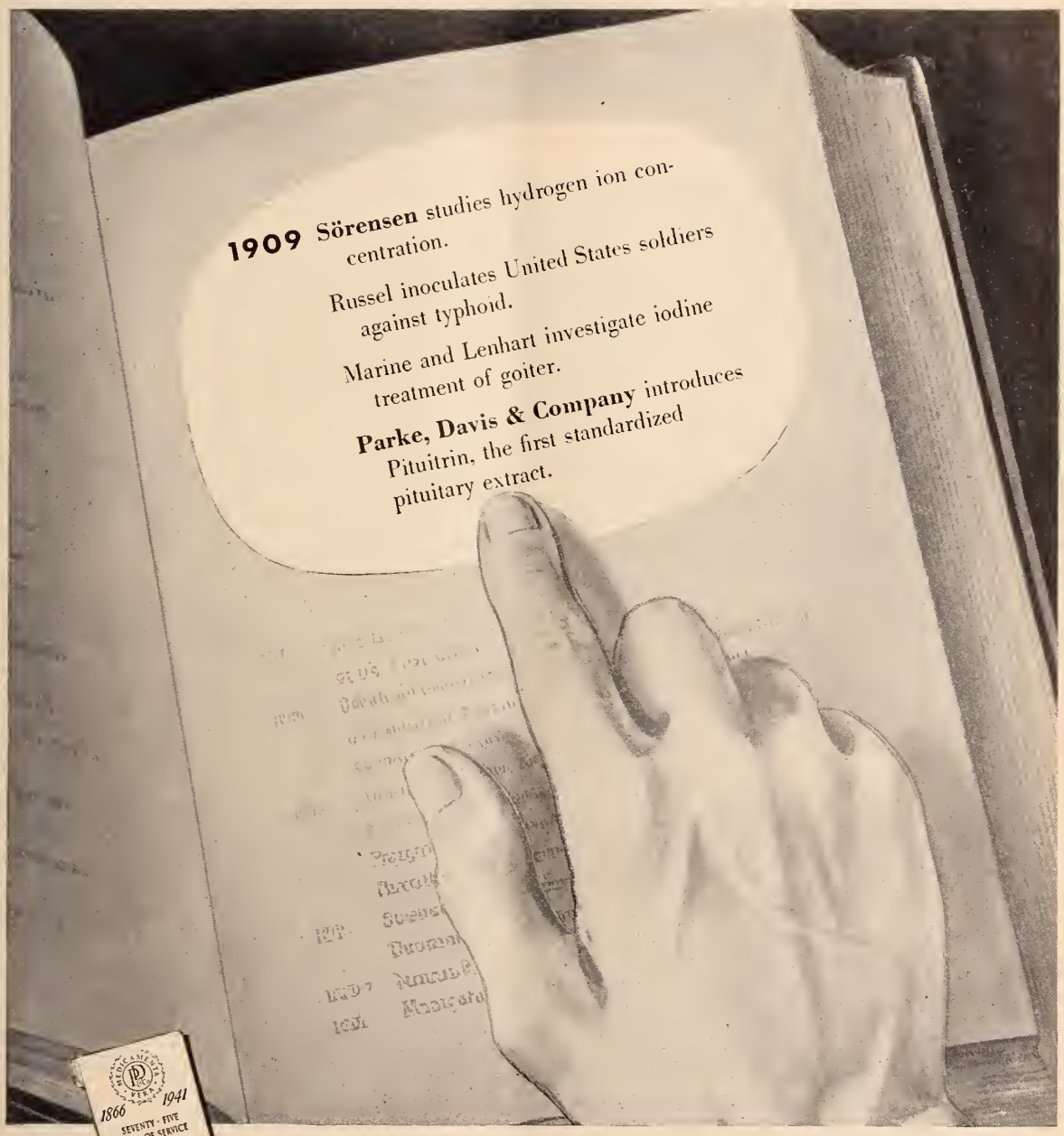

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School of Medicine; Consulting Physician to the New Haven Hospital. Associate Editor, Albert J. Sullivan, M. D., Adjunct Clinical Professor of Medicine, George Washington and Georgetown Medical Schools; Chief Medical Officer, Gallinger Municipal Hospital, Washington, D. C. Cloth. Price (sold only as a set) $40. Pp. 738. New York: D. Appleton-Century Company, Inc., 1941.

The Essentials of Applied Medical Laboratory Technic. Details of How to Build and Conduct an Office or Small Hospital Laboratory at Small Cost. By J. M. Feder, M. D., Director of Laboratories and Allergic Service, Anderson County Hospital, Anderson, S. C. **Blood and Plasma Transfusion.** By John Elliott, ScD., Pathologist, Rowan General Hospital, Salisbury, N. C. Cloth. Pp. 241, with illustrations. Charlotte, N. C.: Charlotte Medical Press, 1940.

(Continued on Page 18)

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Natural Resistance and Clinical Medicine. By David Perla, B. S., M. D., Late Pathologist and Bacteriologist, Montefiore Hospital, New York; Instructor in Medicine, Columbia University; College of Physicians and Surgeons, and Jessie Marmorston, B. S., M. D., Formerly Bacteriologist to Montefiore Hospital; Assistant in Pathology, Cornell University Medical College. Cloth. Pp. 1344. Boston: Little, Brown & Company, 1941.

Oral Pathology. A Histological, Roentgenological, and Clinical Study of the Diseases of the Teeth, Jaws, and Mouth. By Kurt H. Thoma, D. M. D., Professor of Oral Surgery, and Charles A. Brackett, Professor of Oral Pathology, Harvard University. Cloth. Price, $15. Pp. 1306, with 1370 illustrations. St. Louis: The C. V. Mosby Company, 1941.

Proctology for the General Practitioner. By Frederick C. Smith, M. D., M. Sc. (Med.), F. A. P. S., Formerly Associate in Proctology, Graduate School of Medicine, University of Pennsylvania; Fellow, American Proctologic Society; Editor, The Weekly Roster and Medical Digest, Philadelphia County Medical Society; Editor, The Medical World; Lieutenant-Colonel, Medical Reserve Corps, United States Army. Second Revised Edition. Cloth. Price, $4.50. Pp. 466, 161 illustrations. Philadelphia: F. A. Davis Company, 1941.

The Principles and Practice of Ophthalmic Surgery. By Edmund B. Spaeth, M. D., Professor of Ophthalmology in the Graduate School of Medicine of the University of Pennsylvania, Philadelphia; Attending Surgeon, Wills Hospital; Consultant in Ophthalmology, Philadelphia Hospital for the Insane (Byberry); Assistant Ophthalmologist to the Rush Hospital, Philadelphia; Fellow, The American College of Surgeons, Philadelphia College of Physicians; Fellow, The American Academy of Ophthalmology and Oto-Laryngology. Second Edition, Thoroughly Revised.

(Continued on Page 20)

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[1] Cooke, R. A., and Stull, A.: *J. Allergy* 4: 87, 1933.

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Cloth. Price, $10. Pp. 886, 451 Engraved, 1149 Figured illustrations. Philadelphia: Lea & Febiger, 1941.

Medical Diagnosis and Symptomatology. By Samuel A. Loewenberg, M. D., F. A. C. P., Clinical Professor of Medicine, Jefferson Medical College; Assistant Physician to the Jefferson Hospital; Consultant Physician to the Philadelphia Hospital for Contagious Diseases and the Philadelphia Psychiatric Hospital; Visiting Physician to the Philadelphia General Hospital, and the Northern Liberties Hospital; Formerly Assistant Professor of Physical Diagnosis at the Medico-Chirurgical College and the University of Pennsylvania, Philadelphia. Author of "Clinical Endocrinology." Fifth Edition, Revised. Cloth. Price, $12. Pp. 1139, with illustrations. Philadelphia: F. A. Davis Company, 1941.

Arthritis and Allied Conditions. By Bernard I. Comroe, A. B., M. D., F. A. C. P., Instructor in Medicine, University of Pennsylvania; Senior Ward Physician, Hospital of the University of Pennsylvania. Second Edition, Thoroughly Revised. Cloth. Price, $9. Pp. 878, with 242 engraved illustrations. Philadelphia: Lea & Febiger, 1941.

Scabies—Civil and Military. Its Prevalence, Prevention, and Treatment. By Reuben Friedman, M. D., Assistant Professor of Dermatology and Syphilology, Temple University School of Medicine, Philadelphia. Cloth. Price, $3. Pp. 288. New York: Froben Press, 1941.

Essentials of Dermatology. By Norman Tobias, M. D., Senior Instructor in Dermatology, St. Louis University; Assistant Dermatologist, Firmin Desloge and St. Mary's Hospitals; Visiting Dermatologist, St. Louis City Sanitarium and Isolation Hospital. Cloth. Price, $4.75. Pp. 497. Philadelphia: J. B. Lippincott Company, 1941.

(Continued on Page 24)

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*JOSLIN, C. L. and HELMS, S. T., Arch. Ped., 54:533 (Sept.) 1937

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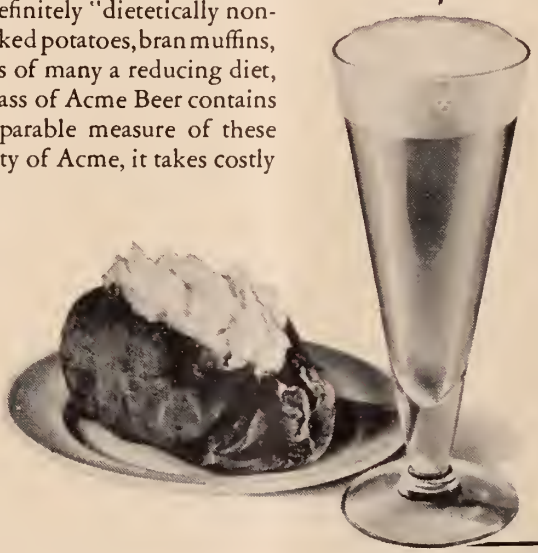

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The New International Clinics. Volume II. Original Contributions: Clinics; and Evaluated Reviews of Current Advances in the Medical Arts. Edited by George Morris Piersol, M. D., Professor of Medicine, Graduate School of Medicine, University of Pennsylvania, Philadelphia, Pennsylvania. Cloth. Pp. 299, with illustrations. Philadelphia: J. B. Lippincott Company, 1941.

The Avitaminoses. The Chemical, Clinical, and Pathological Aspects of the Vitamin Deficiency Diseases. By Walter H. Eddy, Ph. D., Professor of Physiological Chemistry, Teachers College, Columbia University; Director, Bureau of Foods and Sanitation, "Good Housekeeping Magazine," and Gilbert Dalldorf, M. D., Pathologist to the Grasslands and Northern Westchester Hospitals, Westchester County, New York. Second Edition. Cloth. Price, $4.50. Pp. 519. Baltimore: The Williams & Wilkins Company, 1941.

The Mask of Sanity. An Attempt to Reinterpret the So-called Psychopathic Personality. By Hervey Cleckley, B. S., B. A. (Oxon.), M. D., Professor of Neuropsychiatry, University of Georgia School of Medicine, Augusta, Georgia. Cloth. Pp. 298. St. Louis: The C. V. Mosby Company, 1941.

Diet in Sinus Infections and Colds. By Egon V. Ullmann, M. D. Second Edition. Cloth. Price, $2. Pp. 185. New York: The Macmillan Company, 1941.

Essentials of Endocrinology. By Arthur Grollman, Ph.D., M.D., Associate Professor of Pharmacology and Experi-

(Continued on Page 26)

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mental Therapeutics in the Medical School of the Johns Hopkins University; Formerly Associate Professor of Physiology and Instructor in Chemistry in the same institution. Cloth. Price, $7. Pp. 480. Seventy-four illustrations. Philadelphia: J. B. Lippincott Company, 1941.

Accidental Injuries. The Medico-Legal Aspects of Workmen's Compensation and Public Liability. By Henry H. Kessler, M. D., Ph. D., F. A. C. S., Medical Director, New Jersey Rehabilitation Clinic; Formerly Medical Advisor, New Jersey Workmen's Compensation Bureau; Attending Orthopedic Surgeon, Newark City Hospital, Newark Beth Israel Hospital, etc., Hasbrouck Heights Hospital, Hospital and Home for Crippled Children; Member, Council of Industrial Health of the American Medical Association; Hunterian Lecturer, 1935; Fellow of American Public Health Association; Diplomate of American Board of Orthopedic Surgery; Fellow of American Academy of Orthopedic Surgeons. Cloth. Illustrated with 202 engravings. Price, $10. Pp. 803. Philadelphia: Lea & Febiger, 1941.

Mental Disease and Social Welfare. By Horatio M. Pollock, Director of Mental Hygiene Statistics, New York State Department of Mental Hygiene, and Former Editor of the "Psychiatric Quarterly." Cloth. Price, $2. Pp. 237. Utica, New York: The State Hospitals Press, 1941.

Roentgen Interpretation. By George W. Holmes, M. D., Roentgenologist to the Massachusetts General Hospital and Clinical Professor of Roentgenology, Harvard Medical School, and Howard E. Ruggles, M. D., Late Roentgenologist to the University of California Hospital, and Clinical Professor of Roentgenology, University of California Medical School. Sixth edition, thoroughly revised. Fabricoid. Price, $5. Pp. 364, illustrated with 246 engravings. Philadelphia, Pennsylvania: Lea & Febiger, 1941.

Magic in a Bottle. Being the true narratives of ten wonder-working drugs and of the doughty men who, wittingly and unwittingly, discovered them. By Milton Silverman, Ph. D. Cloth. Price, $2.50. Pp. 332. New York: The Macmillan Company, 1941.

Elimination Diets and the Patient's Allergies. A Handbook of Allergy. By Albert H. Rowe, M. D., Lecturer in Medicine, University of California Medical School, San Francisco, California; Consultant in Allergic Diseases, Alameda County Hospital, Oakland, California. Cloth. Price, $3. Pp. 264. Philadelphia, Pennsylvania: Lea & Febiger, 1941.

You Can Be Happily Married. A Manual for Life's Most Important Career, Marriage. By Gilbert Appelhof, Jr., Founder of The Modern Marriage Clinic, Alma, Michigan. Cloth. Price, $2. Pp. 218. New York: The Macmillan Company, 1941.

TWENTY-FIVE YEARS AGO

(Continued from Page 10)

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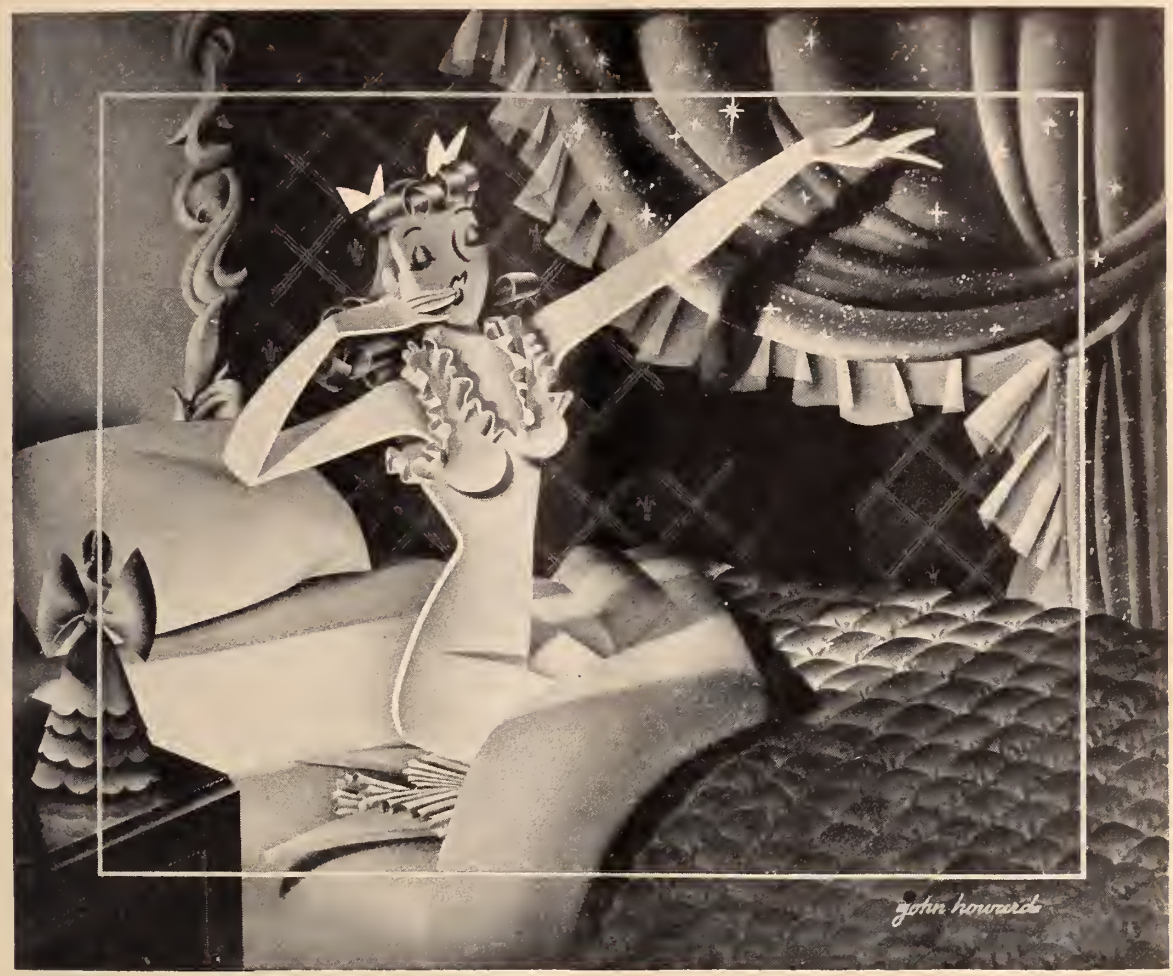
(Continued in Back Advertising Section, Page 30)



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OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 55 JULY, 1941 NO. 1

California and Western Medicine

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Roster of Editorial Board appears in this issue on page 40.

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Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony witb the views of tbe editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. Tbe right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to tbis Journal. New copy must be sent to the editorial office not later than tbe fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in lengtb. Authors wbo wish articles of greater lengtb printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested tbat contributors to this Journal write to its office requesting a copy of this leaflet.

DEPARTMENT INDEX

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EDITORIALS†

COUNTY FAIRS AND THEIR VALUE IN PUBLIC HEALTH EDUCATION: EXPERIENCE OF TEHAMA COUNTY

California's County Fairs.—During this year, 1941, more than fifty county fairs will be opened in the State of California. The place which they hold in the minds and hearts of citizens may best be appreciated by the large number of citizens who visit them, a fact much in evidence during the last decade. Last year, the State Fair—always an outstanding feature of Sacramento—recorded more than 500,000 visitors; and the Los Angeles County Fair, held at Pomona, was credited with an attendance of more than 600,000 persons! In lesser degree, but equally significant, are the attendance figures of the other county fairs.

* * *

Receptive Attitude of Citizens Who Go to Fairs.—It is true that citizens attend fairs for a large number of reasons, as is promptly understood when the diversity of exhibits and entertainment on display are taken into consideration. Nevertheless, even though many go for entertainment, rather than in a primary quest for serious knowledge or factual data, it cannot be denied that, these citizens, having the leisurely mental outlook inspired by a holiday, in the majority of cases, are susceptible to almost any kind of educational attack, provided the approach be made alluring.

* * *

An Excellent Field for Public Health Education.—To make the above applicable in the promotion of public health education, it would seem that organized and scientific medicine need only devise exhibits and entertainment in such form, and under such conditions and auspices, as would be attractive to audiences, brought there through other influences, and who are in mood to be shown.

By contrast, as regards efforts necessary to attract large and changing groups under a nonpublic sponsorship, it is only necessary to consider the trials and tribulations of those who have tried to put over privately sponsored public health or other exhibits and programs.

For the information of members, a list of the county fairs that will be held this year in California is given in this issue. (See page 46.)

† Editorials on subjects of scientific and editorial interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

C. M. A. Committee on Public Health Education Is Coöperating.—Reports in this year's *Pre-Convention Bulletin* pointed out the value of county fairs as vehicles through which public health education could be carried on; the suggestion receiving favorable consideration by the Reference Committee at Del Monte. The recommendation was also considered by the Committee on Public Health Education, that body earmarking an appropriation for transportation costs of exhibits, films and other accessories. The work, therefore, may be said to be under way in California. All that is now needed is the further coöperation of the various county medical societies. For its inspirational value, the story of the recent Tehama County Fair, held at Red Bluff, is here outlined.

* * *

Tehama County Pioneers With a County Fair Exhibit.—It is gratifying to report that to the smallest component society in the California Medical Association (Tehama Society has only ten members) falls the honor of not only being probably the first to present a Public Health Exhibit at a county fair, but also to have demonstrated that this line of education can be carried through in most successful manner.

* * *

The Tehama County Society Experience.—The Tehama County Fair was scheduled to be held June 12-14 (for three days, Friday to Saturday, inclusive). During a visit to San Francisco by Dr. R. G. Frey, president of the Tehama County Medical Society, the suggestion was made by the Association Secretary that the Tehama County Medical Society might perform a real service if it would sponsor a Public Health Exhibit at the county fair then scheduled to begin in a few weeks. Correspondence ensued, and the following results may now be chronicled:

Doctor Frey, without cost, secured an allocation of space in the Fair building from the board of supervisors;

Persuaded a lumber firm to supply material and construct a film booth;

Another citizen to donate the use of chairs;

A large corporation to lend the use of its film projecting apparatus, and the services of an employee on each afternoon and evening to operate the lantern;

Also to have one of the hospitals place a nurse in attendance at the exhibit booths (California Medical Association Golden Gate Cancer exhibit plus two American Medical Association exhibits), and so on.

When the loud speaker announced that the films were about to be shown (three public health strips), people could be seen leaving the stock pavilions for the exhibit building (almost a quarter of a mile distant!). Audiences showed real interest.

The value of the favorable press notices in the local newspapers is hard to estimate.*

As an immediate aftermath, film portrayals were given before a goodly audience of a fraternal order, and requests were received from three service and and other clubs.

The expense to the county society? Probably not more than ten to fifteen dollars!

Contemplate, for a moment, the returns in community good-will for that small amount of money by the county society (the California Medical Association paying transportation charges on shipments of exhibit and other material).

The moral? What Tehama County Medical Society has been able to accomplish should be possible of duplication by other component county units.

Why not urge officers of your own county unit to appoint a County Fair Public Health Committee, its chairman to communicate with the Association Secretary, in line with letters already sent to each county society? Why wait until next year? Today is the time to begin!

* See news item on page 45.

ANNUAL SESSIONS: A. M. A. AND C. M. A.

Important Actions by A. M. A. House of Delegates.—The annual sessions of the American and California Medical associations usually convene within two or three weeks of one another, the constituent state unit for California setting its convention days so as to have at least a two weeks' interval, in order that California Medical Association members, who wish to attend the national organization meetings, may have a better opportunity to arrange convenient travel schedules. At the recent Cleveland session of the American Medical Association, California was listed as having a total of 204 registrants, a very creditable showing when distance and time necessary for travel are taken into consideration. At the Cleveland session of the American Medical Association, business of considerable importance was transacted as may be noted:

Medical Preparedness.—Naturally, matters related to medical preparedness received special attention, and the reports concerning the manner in which the American Medical Association—acting not only for itself, but also for its constituent state associations and their component county units—has been of real aid to the military services, were most illuminating. Certainly, the citizens of the United States have reason to be grateful for the important services that have been and are being rendered by the physicians in every state of the Union, both in their individual and collective relationships, and for both Selective Service and active military work.

Deferments of Medical Students.—It is heartening to know that the problem of deferments for medical students and interns is being solved in quite satisfactory fashion, and that no serious damage will be done to the existing system of medical education and training, the standards of which must be maintained if adequate service is to be made available at all times for citizens in both military and civilian rôles.

Medical Services by Hospitalization Organizations.—A resolution was presented by the California Medical Association, through its Council, designed to instruct the American Medical Asso-

ciation Board of Trustees to appoint a committee of the American Medical Association to confer with similar committees of the national hospital organizations. Action of the American Medical Association House of Delegates:

The proposal to have the conjoint committees to study and submit reports to their respective national bodies in which would be outlined platforms or principles designed to clarify the relation of medical services that may be offered in prepayment hospitalization and similar plans, the same to be in line with the basic principles laid down in the past by the House of Delegates and other authorities of the American Medical Association, was approved by your reference committee, which recommends its adoption.*

Indictment and Trial of American Medical Association.—Equally interesting was the action taken on the Report of the Board of Trustees, considered in executive session, and dealing with the indictment and trial of the American Medical Association, et al. It was stated therein:

The Board of Trustees recommends to the House of Delegates that counsel for the American Medical Association be requested and directed to appeal the judgment based on the verdict of guilty against the American Medical Association in the case of *United States* vs. *American Medical Association et al.*, District Court of the United States for the District of Columbia, No. 63221.

Action taken was

that the House of Delegates heartily approve and commend this report of the Board of Trustees, and the motion was duly seconded.

Dr. T. K. Gruber, Michigan, moved that Doctor Taylor's motion be amended by adding to it the statement that the Board of Trustees be instructed by the House of Delegates to direct counsel for the American Medical Association to appeal the judgment, based on the verdict of guilty, against the American Medical Association in the case of *United States vs. American Medical Association, et al.*, District Court of the United States for the District of Columbia, No. 63221, and the amendment was accepted by Doctor Taylor and his second.

After discussion, Doctor Taylor's *motion as amended was carried by a rising vote, there being not one dissenting vote.*

* * *

Actions Taken by C. M. A. House of Delegates.—The minutes of the C. M. A. House of Delegates appeared on pages 310-342 of the June issue of CALIFORNIA AND WESTERN MEDICINE. Members of the California Medical Association who scanned or read the record of the proceedings at Del Monte are able, therefore, to visualize the many important problems confronting the medical profession in California, and also the manner in which the Reference Committees and the members of the House sought to clarify the issues involved. The reports of the three reference committees should be read by all members and the June issue may well be laid aside for such a purpose. If actions taken at Del Monte are not in accord with local outlooks or needs, members should feel free to bring such items up for further discussion in meetings of their respective county societies. If that is done, it should be possible to secure unified and generous support on pertinent issues. Mention is here made of some of the special matters considered at Del Monte:

State Association Dues of Members in Active Military Service.—Dues of members in active military service will be paid by the California Medical Association, as loans, pending action on an amendment to the Constitution to be considered at next year's annual session (June CALIFORNIA AND WESTERN MEDICINE, pages 328 and 315).

Dues of New Members.—Dues of physicians elected to membership on or after July 1 of a calendar year, will hereafter be one-half the annual dues of that year.

Fund Established for Needy Members.—The House of Delegates instructed the Council "to transfer from the general funds of the Association to this special fund for aid to needy members a sum equal to $1 per each and every active member of the Association."

Coördinating Committees for California Physicians' Service.—The House directed the Council to promote the appointment of "Coördinating Committees" by county medical societies, to coöperate with California Physicians' Service, as explained in a substitute resolution of Reference Committee No. 3 (June CALIFORNIA AND WESTERN MEDICINE, page 333).

Medical Services Rendered Through Hospitalization Organizations.—Resolution No. 14 (June CALIFORNIA AND WESTERN MEDICINE, page 341), dealing with medical services afforded by hospitalization organizations gave certain instructions to the Council. The Council, through a special committee, after conference with interested groups, requested the California Medical Association delegates to the American Medical Association to submit a resolution that had been drafted by the special committee, providing for a clarification of the issues involved, through possible conjoint action by the national medical and hospital organizations (see *Journal of the American Medical Association,* June 14, 1941, page 2700; and June 21, 1941, page 2785).

Promotion of National Physicians' Service.—By unanimous consent of the members of the California Medical Association House of Delegates, the component county societies are urged to further the work of the National Physicians' Committee for the Extension of Medical Services (June CALIFORNIA AND WESTERN MEDICINE, page 341).

Public Health Education Through State and County Fairs.—Public Health Education, through utilization of the facilities of state and county fairs —fields of service hitherto not used in California— was approved by the House, and the California Medical Association Committee on Public Health Education, in line therewith, has earmarked a fund to begin this work.

History of the California Medical Association.—The long neglected collection of historical data (it is a sad fact that the California Medical Association is woefully lacking in historical memorabilia), was taken out of the "filing alcoves of forgotten things" and given approval (June CALIFORNIA AND WESTERN MEDICINE, page 325).

The above (and these are only a few of the matters considered at Del Monte), are referred to because of their special importance.

In due course, the attention of component county societies and members will be called to other items.

* See J. A. M. A., June 21, 1941, page 2792.

ON VARIOUS TOPICS

California State Legislature.—On June 16, the fifty-fourth biennial session of the California Legislature adjourned. There is little new to add to the information already given in CALIFORNIA AND WESTERN MEDICINE (May issue, on page 285, and for June, on page 345). While several measures designed to promote public health activities went down to defeat, the end results, in so far as organized and scientific medicine are concerned, were as good as could have been expected.

* * *

Congress.—The Senate and House of Representatives, at Washington, still in session owing to existing emergencies, has not recently enacted laws inimical to the standards of medical and public health practice, although many such measures have been introduced. It is doubtful whether proposed statutes, modeled after the Wagner Health Insurance Act, will be vigorously pushed during the present session.

* * *

Osteopathic Interns for the Army.—In the California Medical Association Department of Public Policy and Legislation, appears a memorandum concerning efforts to make it possible to employ osteopathic interns in the medical department of the United States Army.*

The matter of osteopathic interns is of considerable importance, for several reasons:

Sectarian schools of the healing art do not maintain standards of preliminary education and of professional training that measure up to those demanded for nonsectarian schools by the Association of American Medical Colleges and Council on Medical Education of the American Medical Association; and

Officers in the medical corps of the United States Army must have graduation credentials from an accredited medical school. They would be handicapped in their work if they were obliged to rely on interns whose concepts of disease and injury were at variance with their own.

Not to be forgotten, also, is what experience has taught: that lowering of standards and appointment of such persons nearly always pave the way for further inroads by such groups.

California Medical Association members who care for additional information in these matters should consult their county society secretaries.

* * *

C. M. A. Annual Session of 1942.—The Council of the California Medical Association is not in position to designate the dates of the next annual session, until the Trustees of the American Medical Association decide the time of meeting of the national organization. Unless a conflict arises, the Council will probably adhere to its custom, and choose the first week of May as the time of gathering for the 1942 annual session.

Members of the Association who contemplate reports on studies should write at an early day to the Secretary of the Scientific Section, before which the paper or address would be given. The roster of Section Officers appears in each issue, on advertising page 6.

The scientific exhibits of the national and state medical associations grow in interest and number with each year. In the June issue, on page 346, was given the list of prize winners at the recent Del Monte session. The Committee on Scientific Work urges all who are in position to present scientific exhibits to begin their preparation at an early date. Correspondence regarding such exhibits should be addressed to the Association Secretary, who is the chairman of the Committee on Scientific Work.

* * *

Antivivisection Propaganda.—During the last several weeks, what seems to be a well-defined effort in antivivisection propaganda has been much in evidence in a well-known string of newspapers, the articles being played up on first pages, in boldface type and with full-page illustrations of supposed examples of cruelties done to lower animals.

Seemingly, little can be done in the premises, since the views of the publisher in question are well known, and it follows that his representatives on the different newspapers take their instructions from him.

It is to be regretted that misinformation, concerning animal experimentation and its value in the prolongation of health and life for both human beings and the lower animals, should be so widely broadcast. The suggestion has been made that the present effort may be part of a plan designed to influence congressmen concerning several pending measures that would be applicable to the District of Columbia, whereby animal experimentation in that national domain, no matter how well and properly safeguarded, would practically be prevented.

Propaganda campaigns of this kind, through which the interests of scientific medicine and the public health are jeopardized, only emphasize the need and value of sound public health education through other channels than that to be had by purchase of expensive newspaper advertising space. Such a medium is at hand in the state and county fairs of California, concerning which editorial comment is elsewhere made in this issue. With the coöperation of county societies and their members, this method of education could be developed in such wise as to neutralize, in large measure, the dogmatic and misleading statements of some of the sponsors of so-called antivivisection propaganda.

CHANGES IN OFFICIAL JOURNAL'S FORMAT: EDITORIAL BOARD

Changes Conserve Space and Money.—CALIFORNIA AND WESTERN MEDICINE this month changes its format slightly. The difference is intended as a convenience to the reader and an economy to the publisher. Type pages remain the same size as before, but margins have been trimmed a bit. Editorial features are included in this issue in the same form as in the past. Advertising pages

* Members who wish to write to the United States Senators and Representatives from California will find the names of the Congressmen on page 285 of the May issue. See also informative item on page 44.

have been somewhat rearranged, with nothing omitted, in order to accomplish an economy of space; the additional pages thus made available will be used for the publication of additional scientific material.

Together with a change in binding made several months ago and a change in paper stock made last month, the new format of this issue brings into complete being a program of publication economy long discussed and recently agreed upon by the Council of the Association. It is hoped that this program will make the pages of CALIFORNIA AND WESTERN MEDICINE even more valuable to its readers than in the past, and at the same time will accomplish monetary economies that will be reflected in the Association's financial statements.

* * *

Editorial Board for "California and Western Medicine."—At Del Monte, the Council appointed an Editorial Board to whose members will be referred annual session manuscripts. The executive committee of the Board will coöperate with the Editor and Committee on Publications. (See June issue, on page 351.) The representatives of the specialty groups who are members of the Editorial Board are as follows:

Chairman of the Board:
George D. Barnett

Executive Committee:
Sumner Everingham, Oakland, Chairman.
Mast Wolfson, Monterey.
Albert J. Scholl, Los Angeles.
George W. Walker, Fresno.
Chauncey D. Leake, San Francisco.

Anesthesiology:
Charles F. McCuskey, Glendale.
H. R. Hathaway, San Francisco.

Dermatology and Syphilology:
H. J. Templeton, Oakland.
William H. Goeckerman, Los Angeles.

Eye, Ear, Nose, and Throat:
Frederick C. Cordes, San Francisco.
L. G. Hunnicutt, Pasadena.
George W. Walker, Fresno.

General Medicine:
George D. Barnett, San Francisco.
George H. Houck, Los Angeles.
Mast Wolfson, Monterey.

General Surgery (including Orthopedics):
Frederick C. Bost, San Francisco.
Clarence J. Berne, Los Angeles.
Sumner Everingham, Oakland.

Industrial Medicine and Surgery:
Richard O. Schofield, Sacramento.
Delos Packard Thurber, Los Angeles.

Plastic Surgery:
George W. Pierce, San Francisco.
William S. Kiskadden, Los Angeles.

Neuropsychiatry:
John B. Doyle, Los Angeles.
Olga Bridgman, San Francisco.

Obstetrics and Gynecology:
Erle Henriksen, Los Angeles.
Daniel G. Morton, San Francisco.

Pediatrics:
William A. Reilly, San Francisco.
William W. Belford, San Diego.

Pathology and Bacteriology:
David A. Wood, San Francisco.
R. J. Pickard, San Diego.

Radiology:
R. R. Newell, San Francisco.
Henry J. Ullmann, Santa Barbara.

Urology:
Lewis Michelson, San Francisco.
Albert J. Scholl, Los Angeles.

Pharmacology:
Chauncey D. Leake, San Francisco.
Clinton H. Thienes, Los Angeles.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 37.

EDITORIAL COMMENT†

NEOPLASTIGENIC SENSITIVITY

The development of technical methods for the study of "latent neoplasms" or "subthreshold neoplastic states," is currently reported by Rous,[1] Kidd and MacKenzie,[2] of the Rockefeller Institute.

When a carcinogenic agent is applied to mammalian skin it nearly always elicits preliminary benign growths. These precancerous states have thus far received relatively little attention, due largely to the fact that in the mouse, the commonest experimental animal, the initial "warts" are prone to become malignant very soon. In rabbits, however, the initial neoplasms retain their benign character for long periods of time,[3] only a small percentage of them becoming malignant after months or years of repeated tarring. If the tarring is interrupted in the benign stage, the growths almost invariably dwindle and disappear, the skin being restored to apparently normal. About ten years ago, however, it was shown by des Ligneris[4] of South Africa, that this restoration is physiologically incomplete, the apparently normal skin remaining for many months hypersusceptible to tar. On reapplication of tar there is an explosive response, new warts often appearing within 10 days as contrasted with the 5 months tarring required in normal controls. This acquired neoplastigenic allergy or hypersusceptibility is described by Rous and his coworkers

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

1 Rous, P., and Kidd, J. G.: Jour. Exper. Med., 7:365 (Mar.), 1941.

2 MacKenzie, I., and Rous, P.: Jour. Exper. Med., 73:391 (Mar.), 1941.

3 Rous, P., and Kidd, J. G.: Jour. Exper. Med., 69:399, 1939.

4 des Ligneris, M. J. A., Annual Report of the South African Institute for Medical Research, 1930, 1.

as a "subthreshold neoplastic state," or heightened "neoplastic potentiality." In his hands carcino-hypersensitive skin will respond equally well to nonspecific irritants. Explosive wart formation, for example, follows the application of such non-carcinogenic agents as acetone or turpentine or as a result of local mechanical trauma or wound healing.

By repeatedly tarring of rabbit skin throughout a period less than that required to elicit macroscopical growths, the Rockefeller Institute oncologists showed that "many more cells are rendered potentially neoplastic than ever assert themselves in tumor formation under ordinary experimental conditions." After a rest period of six or more months, the treated skin may respond to local mechanical trauma (wound healing) by explosive neoplastic growths. This observation is in line with the popular belief that trauma may lead to local cancer. Demonstration that a previous carcinogenic sensitization is necessary for the development of such "traumatic cancers," however, is a new observation, which eventually may prove to be of basic clinical interest. The essential cause of the presumptive "traumatic cancer" may well have been a virus or other carcinogenic agent, which "may have done its work years before and the cells it rendered neoplastic [may have] remained ever since within their morphological context, incapable of asserting themselves until some intercurrent accident—a blow, a wound, a burn—stirs them to proliferation." The medicolegal bearing of this synergic theory is obvious.

P. O. Box 51.

W. H. Manwaring,
Stanford University.

SKIING INJURIES

During the past season of skiing in the Sugar Bowl area, near Norden, California, 153 persons received first-aid for accidental injuries sustained while skiing. This service was provided by members of the Sugar Bowl Ski Club, expert skiers who are trained in first-aid performance under the difficult conditions of snow-covered, mountainous terrain.

Of these 153 cases, there were thirty simple fractures of the tibia or fibula, or both bones together, and two fractures of fingers. Other serious injuries included three dislocations of the shoulder joint, and seventy-six sprains of the ankle or knee joint of varying degrees of severity. The remaining thirty-two cases suffered from cuts, puncture wounds, contusions and abrasions sufficiently painful to lead the victim to apply for treatment.

It is difficult to count accurately the skiers who are using the slopes of this region, but estimating their number from reports of the transportation services to and from the Sugar Bowl area, the incidence of injury is found to be about 1 per cent. This probably represents the highest accident rate of any American sport.

In spite of study by the National Park Service, various ski clubs, and other interested organizations, very little has been accomplished toward reducing the hazards of skiing. With the increasing popularity of this sport, a steady rise in the number of resulting injuries must be expected, and facilities provided minimizing their harmful results.

450 Sutter Street.

John Galgiani,
San Francisco.

PREVENTION OF FLAT FEET

The human foot is not a perfectly adapted structure. Evidence points to the fact that a pronated foot is more likely to give rise to pain on prolonged standing or walking than is a supinated foot. When mild varus (inversion) deformity gives rise to pain, it does so principally as the result of callus formation on the lateral aspect of the foot. It does not, however, cause severe aching pain that a reverse deformity of valgus (flat foot) of equal severity may cause. On weight bearing, the normal foot is constantly being thrust into a position of valgus or pronation.

Few will deny that the therapy of pronated feet is not satisfactory. This is evidenced by the multiplicity of methods of treating pes valgus. Many of the methods, indeed, are based on diametrically opposite principles. For instance, Blundell Bankhart believes the longitudinal arch of the foot in an individual with painful pes valgus should be flattened completely. Most authorities believe that every effort should be made to increase the height of the longitudinal arch by the use of arch supports or shoe corrections.

Can flat feet be prevented? Most prophylactic measures for pes valgus are performed on children from three to thirteen years of age. But is this not too late to start prevention? The Chinese, when they wished to reshape a foot into the type they considered beautiful, started binding the feet at an early age. We do not wait to correct an obvious club-foot (equino varus) until the child is three, but we prefer to start shortly after birth.

It seems to me that it would be desirable to strap all infants' feet with adhesive tape into a position of varus a few days after birth. The obstetrician and pediatrician could do this just as easily as they prescribe formulae for infant feeding. Strapping could be continued for a period of one month. The resultant atrophy of the leg musculature would be negligible. Another objection that might be raised to this procedure is that the new-born's foot is normally slightly inverted. However, this inversion disappears within one week after birth, leaving the infant's foot in valgus (flat foot) position.

By inauguration of such a program, we should at least be more prone to recognize and treat infants with obvious or mild valgus deformities at an earlier age. Our army, in later years, might then not be depleted by so many men complaining of "flat feet."

Station Hospital,

L. N. Cozen,
Fort Lewis, Washington.

ORIGINAL ARTICLES

PEYRONIE'S DISEASE OR FIBROUS CAVERNOSITIS: SOME OBSERVATIONS*

By E. W. Beach, M. D.
Sacramento

DEFINITION.—Peyronie's disease, fibrous cavernositis or plastic induration of the penis, connotes an abnormal fibrous thickening or fibroma elaboration limited to the tissues over the dorsum of the penis. The septum or sheaths of the corpora cavernosa are involved with extension in an asymmetric manner into the tunica albuginea. The unique character and unequal distribution of this fibrous change ultimately makes for painful angulation or deformity in the erect penis, so that coitus is difficult or impossible.

Purpose of This Article.

This article has a very modest and simple objective. It seeks to focus the attention of the general practitioner (since all urologists have been initiated) upon that morbid entity captioned "fibrous cavernositis," to the end of a better understanding for the sufferer and his symptom complex. Contrary to custom in treating of fibrous cavernositis, this article shall attempt no diligent abstract of the exhaustive bibliography; it shall constitute no *vade mecum* nor syllabus of authoritative quotations; it shall venture no new descriptive synonym; it shall recount no unusual histological discovery; it shall compile no grad-grind table of statistics, and it shall undertake no blitzkrieg on the disease by reason of an infallible or personalized remedy. In fine, this paper expressly concerns itself with the more practical aspects of fibrous cavernositis, and hopes to foster thereby wider recognition of the malady and a more sympathetic treatment withal.

Need for Recognition of Fibrous Cavernositis.

The need for more universal recognition and fuller comprehension anent fibrous cavernositis is self-evident to any urologist of experience. Moreover, there exists currently an exiguity of scientific literature treating of the subject, save in highly specialized journals with a narrow circulation. Almost twenty years of urological observation, plus close professional rapprochement with a host of general practitioners during this interval, have sponsored certain tenets with regard to the malady. These might be tabulated somewhat as follows:

1. Perhaps no *obvious lesion* (leastwise not in the urological realm) constitutes a greater stumbling-block for the general practitioner, and certainly none is more often muffed by him. It is astounding the number of men who have never even heard of fibrous cavernositis. Others quite innocently inaugurate treatment for chordee, stricture, "enlarged lymph gland," dorsal thrombophlebitis, lymphangitis, or cancer. To substantiate this contention, a series of twelve referred cases will directly be examined, eleven of which were either erroneously diagnosed or not diagnosed at all. At the behest of accuracy and for comparative purposes, this series is arbitrarily limited to patients under observation and treatment for at least nine months. (Seven additional cases are not included because they failed to tarry the prerequisite time and with characteristic impetuousity did a "fade out"—never to return.)

2. Few diseases have a greater psychic complexion and in none is the mental anguish more genuine. Mindful of the basic nature of the sexual impulse and its relation to the personality ensemble, the effect of copulative frustration, either by reason of pain or physical distortion, or both, is an item of first magnitude. The corresponding reaction depends somewhat upon the age, temperament, and actual degree of contravention.

3. The victim is usually afflicted, likewise, with a wanderlust that thwarts prolonged observation and defeats rational treatment. With all the zeal of a Sir Galahad, he organizes a quest for cure. In vacillatory crescendo he "makes the rounds" and often ricochets into the charlatan's office. Time, money, and effort are vainly expended, so that eventually the patient becomes despondent, uncoöperative and disgruntled, or "sours" on the profession generally. Suicide may close the picture.

4. Since no form of therapy is currently entirely satisfactory (as attested by the number and diversity of remedial expedients), it still becomes necessary to invocate the art of practice as in the days of yore. The modern physician is long on science, but short on art.

To justify these tenets and to expedite the objective, it seems logical, first, to examine the clinical material and then to stress some of the highlights of this morbid entity.

FIBROUS CAVERNOSITIS

Synonyms.—This morbid entity was first described by that celebrated French surgeon, Franciscura de la Peyronie (1678-1747). The many contributors since his time have added but little to his original exposé, save an imposing array of formidable synonyms and fantastic etiological theories. A few of the commoner synonyms are, to wit: Peyronie's disease, Van Buren's disease, plastic induration of the penis, fibrosclerotic plaque, indurated plaque, enchondroma, fibrosclerosis, nodes, ganglia, plastic concretions, and fibrous tumor of the corpora cavernosa.

Occurrence.

Peyronie's disease is no respecter of persons, but attacks with equal facility men in all walks of life. The commonest age of visitation is from fifty to sixty, but not without some rivalry in the ensuing decade. Occasionally, much younger men are harassed similarly.

Judgment based solely upon reported cases (presently some 630) would seem to indicate the rarity of this malady. Conclusions of this sort

* Read before the Section on Urology at the sixty-ninth annual session of the California Medical Association, Coronado, May 6–9, 1940.

CLINICAL MATERIAL

INITIAL	AGE	COMPLAINT	DURATION (RELATIVE)	TYPE OF LESION	DIAGNOSIS (REFERRED)	GONORRHEA (PREVIOUSLY)	SYPHILIS (WASSERMAN)	TREATMENT	OBSERVATION PERIOD (RELATIVE)	RESULT
1 RP	54	Pain – bending to right side	18 months	Nodes – right and behind gland	Enlarged lymph gland	No	Yes	Antiluetic Operation	20 months	Improved 6 months scar recurred
2 LS	61	Pain – bending to right side	?	Nodes – midline and right corpora	Chordee	Yes	No	K I Operation	9 1/2 mos	Improved
3 CH	53	Pain- bending to left side and upwards	3–4 years Progressive	Midline – left corpora and base	Lymphangitis	Yes	No	K I Operation	14 months	Improved initially scar recurred
4 YC	57	Pain – bending upwards	3 years Progressive	Nodules at base and midline	Chordee	No	No	X-ray K I	2 years	Fair
5 MH	58	Pain-slight bending to left side	3 months	Midline – left side	Chordee	Yes	No	X-ray K I	10 months	Improved
6 MV	63	Pain – some bending upwards	2 years Progressive	Midline and base	Stricture	Yes	No	X-ray K I	14 months	Slightly Improved
7 JH	59	Pain – no angulation Flaccidity (Partial)	6 years Progressive	Midline and both sides equally	Dorsal thrombo-phlebitis	?	No	X-ray Au No-thiosulfate	12 months	Improved
8 BO	55	Pain-slight bending to left side	3 months	Midline – left side	None	Yes	No	Radium element K I.	9 months	Questionable
9 HZ	56	Slight pain little angulation	6 months	Midline	Chordee	Yes	Yes	Radium element Antiluetic	7 years	Definitely improved
10 WL	51	Pain – right angulation	10 months ?	Midline – right side	"Fibro-sclerosis"	?	Yes	Antiluetic Diathermy Au No-thiosulfate	5 years	No change
11 WW	57	Pain – no angulation	3 years Progressive	Midline – symmet-rical	Concer ?	No	No	K I Diathermy Au No-thiosulfate	18 months	Slightly Improved
12 JB	53	Pain – right angulation	1 year	Midline – right corpora	?	Yes	No	K I Au No-thiosulfate	16 months	Slightly improved ?

are likely erroneous, because most of the afflicted are seen by the general practitioner and seldom reported. Reticence or embarrassment (his manhood being challenged) may interdict consultation. Manifestations may be slight and punctuated by long periods of quiescence. Modest anatomic change, especially if attended by more equable or fairly uniform distribution, provokes little inconvenience. Homogeneous and adjacent or axisymmetric nodes facilitate counterpoise in the erect organ and thereby tend to offset or negate distortional influences. Moreover, since these symptoms are prone to occur in an era of shifted sexual values (elimination now holds the greater psychological interest) adequate compensatory adjustment may be forthcoming without medical advice.

Clinical Factors.

Symptoms are rather consonant to the degree, extent, and type of morbid deviation. Invariably, some shade of copulative difficulty brings the patient to the physician. Pain, which is experienced only when the phallus is turgid, may discourage or actually preclude coitus. The erect organ may bend upward (when maximum involvement is at the base) or be angulated to one side (always in the direction of the greatest pathologic change because of resultant segmental inelasticity) in such a manner as to hinder or technically prevent intromission. A combination of both pain and deformity may accrue with accent on either.

Examination of the penis discloses a palpable thickening limited usually to the dorsum. This thickening may be most conspicuous in the midline along the septum and advance in a linear manner over the sagittal plane of the phallus, only to spread laterally in an unequal fashion across the sheaths of the corpora. One, or a series of plaques or nodes, often bosselated in character, with distinct edges, either in the midline or sweeping laterally toward but not involving the caput or glans, are plainly felt. These nodes (which sometimes are hyperesthetic to touch, but more often

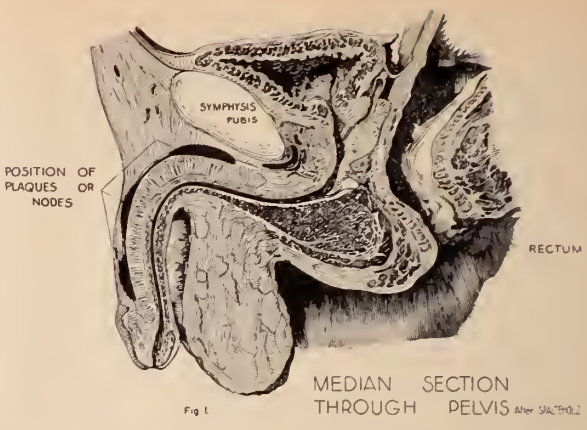


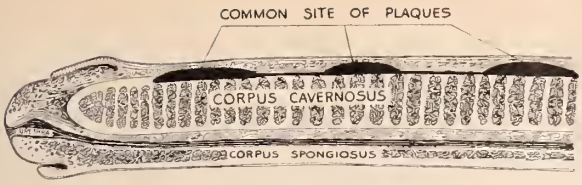
Fig 1

responsive only to firm compression or vehement squeezing) are never attached to the skin above nor do they invade the bodies of the corpora cavernosa beneath. The corpus spongiosum is never affected (Figs. 1, 2, 3). These plaques have usually a rubbery or cartilaginous consistency, but may be dense, unyielding, or even bonelike in substance. For a graphic picture, one might conceive the phallus bedecked with a miniature western-type saddle, the saddle to be equipped with a pelican horn, or horns, and either being somewhat askew in position or having an abbreviated skirt and fender on one side. In our brief series, the "horns" were oftenest in the midline or behind the caput, rather than at the base of the penis.

The clinical course of Peyronie's disease is both whimsical and quite unpredictable. No definite pattern is followed. That this disease is both insidious in onset and slow in development is manifested by the years which often lapse between the prodromal symptoms and the time when the physician is first consulted. Moreover, clinical observation has proved that this disease may lie dormant for long periods without progress. Improvement may occur spontaneously with or without treatment. Spontaneous cures have been reported, but are equivocal. Any change, whether benevolent or sinister, is apt to be subtle and dilatory in character. Prognostic forecasts should, therefore, be guarded and cognizance taken of this bizarre demeanor.

MORBID ANATOMY

The findings in our three operative cases were nearly identical with variance only as to distribution. In each instance, a pearl-gray, glistening scar-like tissue of unbelievable density was moulded heterogeneously and almost inseparably over the septum and dorsal aspects of the tunica albuginea. At divers points, this tissue, with rather a striated appearance, was concentrated into mounds, heaps, or nodules. Extirpation was difficult, and the knife blade rasped harshly over the cut surface. Histologic sections revealed a cellular architecture not unlike hard fibroma, *i. e.*, compact bundles of connective tissue with a paucity of cellular elements. Here and there coarse collagenous fibers arranged in close parallel formation were apparent. No inflammatory change nor round-cell infiltration was evident. No calcific deposition nor osseous metaplasia was discernible.



SAGGITAL SECTION THROUGH PENIS

Fig 2 After PIERSOL

ETIOLOGY

The causative factor is unknown. Trauma appears more plausible than factual. From a practical standpoint, actual trauma—worthy of etiologic note—must be vouched for and accompanied by congruent physical evidence. The rôle of lues, gonorrhea, diabetes, gout or arthritis is unproved. Moreover, effective treatment of these coexistent disorders is rarely productive, and antisyphilitic therapy (if the Wassermann is positive) seldom avails herein. The age incidence suggests a degenerative or retrograde change bound up with the problem of senescence.

This fibroma, or keloid-like formation, may eventually undergo metaplasia, with transformation into cartilage or osteoid tissue. That such a distinctive pathological entity could be a phylogenetic throwback, or even remotely related to the os penis or os priapi, an anatomic and physiologic structure normally present in certain lower animals, seems fatuous. Pohl,[1] who has done much work on the male copulatory organs of mammals, points out that certain mammal groups have a terminal corpus cavernosum on the pars intrapreputialis, forming a caput penis which frequently presents a bony structure in the "corpus fibrosum." This bone, which is replete with true osseous elements, has a characteristic shape and form for each species and lies in the glans or caput. Anatomically this bone is situated dorsal to the urethra, which it often partly surrounds and in close proximity to the corpus spongiosum. Figure 4, a sagittal reproduction of the seal's penis (which is fairly representative) graphically illustrates how dissimilar in size, position, and form is the anatomic os priapi to those morbid lesions commonly encountered in Peyronie's disease.

The undaunted proponent of atavism may find support in the study of the "tail" of certain primitive amphibia, although phallic evolution really begins with the disappearance of the cloaca. The presence therein of certain peculiar acellular or sesamoid-like bones—the Nobelian bones[2]—more recently studied by de Villiers[3] in the Ascaphus may have some etiologic import in plastic induration.

DIFFERENTIAL DIAGNOSIS

The subjective and objective symptoms should signalize Peyronie's disease.

Plastic induration, because of the penile angulation, is often confused with chordee. Chordee is always contingent upon lusty urethral inflammation (usually gonorrhea, heroic therapy or stricture formation), with secondary implication of the subjacent corpus spongiosum. Since the inelastic segment is beneath the urethra, the turgid penis bends down (instead of to the side or upward, as in Peyronie's disease) with painful manifestations, dependent upon the inflammatory reaction.

BLACKED AREAS INDICATE ANATOMICAL POSITION OF NODES OR PLAQUES

CROSS SECTION THROUGH PENIS — After PIERSOL

Fig. 3.

The inflammatory nature of acute cavernositis and dorsal thrombophlebitis distinguishes these entities. Traumatic sclerosis following injuries, wounds or fractures of the cavernous bodies, is readily differentiated from plastic induration.

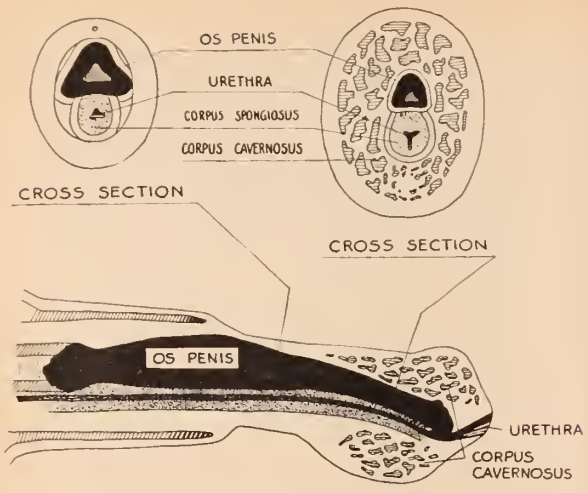
Rare instances of massive bone deposition in the penis, roentgenologically apparent but both regionally and etiologically obscure, should not be confounded with Peyronie's disease.

Syphilitic gummata or cavernositis is uncommon and involves the spongy tissue rather than the tunica albuginea. Hence, there is no angulation and the lesion is tractable to antiluetic therapy.

Carcinoma usually begins in the glans or about the urethra. It is destructive in character, painful by nature, and often ulcerates early. A biopsy confirms the diagnosis.

TREATMENT

The management of this disease tries the soul of the conscientious physician (not to mention the patient's) and makes him wish for proximity to Mimir's well. Any possible choice from his armamentarium is apt to shoot wide of the mark, whether he selects the more conservative fibrolytic bullet, either medicinal (such as potassium iodid, fibrolysin, or more recently and quite empirically, sodium gold thiosulfate) or physical (such as diathermy, radium element and x-ray), or whether he fires the more radical bullet of extirpation. Most of these fibrolytic bullets are poorly designed or pack charges quite inadequate for the task at hand, so that the finest clinical spotting scope is often unable to discover a "hit" (*i. e.*, detect a com-



SAGGITAL SECTION THROUGH SEAL'S PENIS — After POHL Fig. 4

mensurable gross change in the morbid lesion), and achievement must be predicated solely upon the patient's asseveration. With the high velocity bullet of extirpation, the initial relief is usually propitious and striking, but the end-result is often conditioned by subsequent recurrence of the scar tissue.

Obviously, there is no specific for fibrous cavernositis, and more apt therapy necessarily awaits upon etiological enlightenment. Moreover, there are too many imponderables bound up with the personal equation, and the vagaries of this disease to set forth any therapeutic regime for universal application. Treatment must, therefore, be suited to the individual in every instance—first, last, and always.

Consideration of Therapy.—No *exact* evaluation of the various modalities used herein is possible because of: (1) the meager clinical material studied, (2) the personal equation (inclusive of the morbid change and the particular shade of sexual incompatibility), (3) the enigmatic course of the malady, and (4) the relative and intangible character of the end-results, as reported by those under treatment. We must, therefore, content ourselves with impressions and a brief discussion of the different therapeutic vehicles utilized.

Medicinal Treatment.—We have seen no tangible or physical evidence of benefit from either sodium gold thiosulfate or potassium iodid, although cures have been reported following the use of the latter.

Medical Diathermy.—While the action and usefulness of this vehicle may be questioned somatically, it has demonstrable merit psychically and especially with the more intelligent patient. Treatments may be given in the office or, better, as advocated by Wesson,[4] a telatherm or small diathermy machine (so adjusted that no burn or harm can occur and equipped with a special penile electrode) may be given the patient for use *ad libitum* in his home. Wesson reports two cases so treated, and under observation for over seven years, as clinically "cured."

Radium and X-ray.—Radium element, properly screened, was used for an average of 180 mgh. The exact dosage, the number of applications, and the region treated was conditioned by the pathologic change at hand. X-ray therapy was similarly regulated, and exposure (standard 200,000 volt apparatus) usually equaled one-third of an erythema dose for five treatments at five-day intervals. This therapy was under the supervision of Dr. O. S. Cook, radiologist at the Mercy Hospital. Both these potentialities have value, but end-results appear a stand-off. They should be given a fair trial, individually or in combination, in the more urgent case before resorting to surgery.

Operation.—This procedure should be reserved for the more adamant and difficult case. It is interesting to note that two of our operative cases were undertaken because of importunities of the wives concerned. The patient should be apprised of possible sequelae. Plastic concepts should be closely followed, and the incision made accordion-pleated rather than linear, to obviate recurrent scar formation. For the same reason, adroit handling of the tunica albuginea is expedient. Results depend, in no small measure, upon the skill of the surgeon and his knowledge of plastic technique.

CONCLUSION

1. Neither cause nor cure for Peyronie's disease is presently discernible.
2. This disease, which is insidious in onset, has greatest incidence after fifty, and the nodes, which are seldom tender, eventually betray their presence by deflected erections with concomitant pain.
3. The diagnosis is frequently missed because of a cursory examination.
4. Psychic trends are often conspicuously associated with Peyronie's disease.
5. An indurated plaque with distinct edges and tightly adherent to Buck's fascia is pathognomonic.
6. These plaques, which involve only the septum or the tunica albuginea, or both, initially comprise dense fibrous tissue, but may later undergo cartilaginous, osteochondrous or osseous metaplasia.
7. Since spontaneous regressions are common in this disease, the last remedy used may be falsely credited with cure and mistakenly extolled.
8. Surgical results are conditioned by the plastic skill of the operator and his ability to prevent recurrence of scar tissue.

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SKIN REACTIONS PRODUCED BY 200 KV AND 1000 KV RADIATIONS: A COMPARISON*

By Robert S. Stone, M. D.
and
J. Maurice Robinson, M. D.
San Francisco

BEFORE the roentgen was available as a measure of exposure, the erythema of the skin was used as the measure of dosage, and those amounts of irradiation from different x-ray generators that produced equal erythemas on similar skins were considered to represent equal doses. The authors of this study undertook to determine whether or not similar skin reactions could be produced by high voltage radiations of widely different qualities when using the fractionated method of treatman and, if so, what the measure in roentgens of each quality would be. This work represents another attack on the problem: Is there an inherent difference in the biologic action of radiation generated at different voltages, or can the dosage for the different qualities be so adjusted as to produce similar biologic effects?

METHOD USED

The method used was to treat the right side of the pelvis of patients with uterine cancer, front and back, with 200 kv radiations (H V L 1.05 Cu) one day, and the left side, front and back, with 1000 kv radiations (H V L 9.5 Cu) the next day. The sides treated were alternated daily throughout the course of treatments of about thirty days.

Table 1.—*Illustrating the Method of Calculating Dosage*

M.R. Age 42. 16 cm thick.
Four 10x15 fields, 12 treatments to each in 27 days
One day, rt. front and back — 200 kv
Alternate day, lt. front and back — 1000 kv

	Per Treatment		Total	
	200 kv	1000 kv	200 kv	1000 kv
(1) r in air	200	275	2300	3162
Backscatter	36% 72	9% 25	828	284
(2) r c b.s.	272	300	3128	3446
Exit dose	12% 33	25% 75	375	862
(3) Total skin dose	305	375	3503	4308

Ratio $\frac{200\text{kv}}{1000\text{kv}}$ (1) in air $\frac{100}{137}$, (2) c b.s $\frac{100}{110}$, (3) Total skin dose $\frac{100}{123}$

Two hundred r (air measure) per port was used as the standard with the 200 kv radiations, and the amount with the 1000 kv radiations was varied from group to group. The r per minute was kept approximately the same for both qualities.

The exposures were measured in roentgens by a Victoreen condenser r meter (thimble chamber). They were recorded as roentgens in air, roentgens on the skin (r in air + backscatter), and total skin dose in roentgens (r on skin + exit dose). The "total skin dose" is the only accurate measure for comparison, since it alone includes all of the radiations acting on the skin and takes into consideration the size of the field and the thickness of the patient (Table 1).

The skin reactions were recorded at several stages of their evolution by means of kodachrome color photographs. By comparing adjacent areas of the same individuals treated by the two qualities of radiations on the same photograph, not only was the problem of different sensitivities of different skins eliminated, but the pitfalls of visual memory and of subjective bias. The reactions compared were those of the anterior surfaces.

* From the Division of Roentgenology, University of California Medical School, San Francisco.

Read before the Section on Radiology at the sixty-ninth annual session of the California Medical Association, Coronado, May 6–9, 1940.

This study has been aided by grants from the Christine Breon Fund for Medical Research, and the Anna Fuller Fund.

Note: Since the above article was submitted, a more extensive discussion of this subject by the authors has been published. Stone, Robert S., and Robinson, J. Maurice: A Comparison of Skin Reactions Produced by 200 k.v. and 1,000 k.v. Radiation, American Journal of Roentgenology and Radium Therapy, 44:601–609, 1940.

This article contains illustrations in color, of which those in the present article are the black and white counterpart.

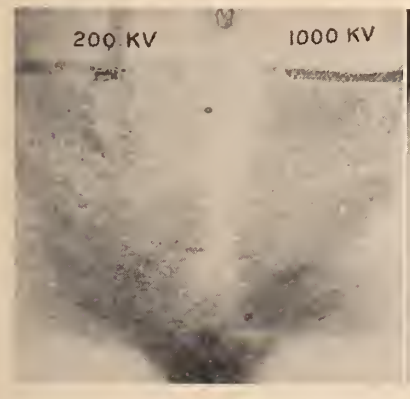

Fig. 1*a*

Fig. 1*b*

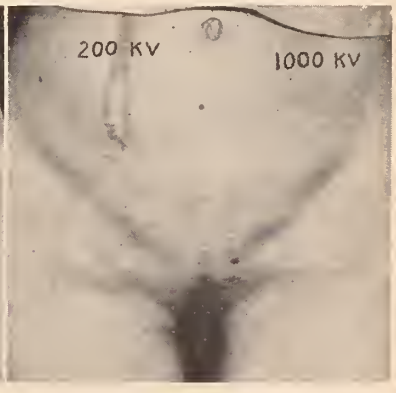

Fig. 1*c*

Comparison of skin reactions produced by radiations of widely different quality: 200 kv on patient's right side 1000 kv on left. *Black crusts caused by application of 10 per cent tannic acid to blistered areas.* Original photos were in color (Kodachrome).

Figs. 1*a*, 1*b*, 1*c*. E. C. (see table 2). Three stages in evolution of *equal* skin reactions. 23 per cent more roentgens in total skin dose on left (1000 kv) side

Fig. 1*a*.—31 days after beginning treatment, 8 days after end. Reactions about equal. Fig. 1*b*.—37 days after beginning, 8 days after end. About equal. Fig. 1*c*—120 days after beginning, 91 days after end. Both sides have recovered at the same rate and to the same degree.

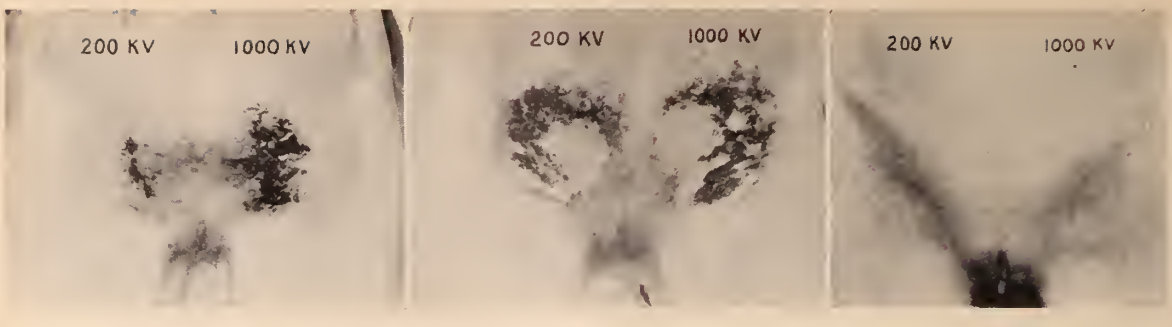

Fig. 2*a* Fig. 2*b* Fig. 2*c*

Figs. 2*a*, 2*b*, 2*c*. E. B. (see table 2). Three stages in evolution of equal skin reactions. 22 per cent more roentgens in total skin dose on left (1000 kv) side.

Fig. 2*a*.—30 days after starting treatment, 3 days after end. Quite extensive blistering on *left* (1000 kv) side, blackened with tannic acid. Reactions otherwise very similar. Fig. 2*b*.—35 days after starting, 8 days after end. Nearly equal reactions on the two sides. Fig. 2*c*.—50 days after starting, 23 days after end. Reactions have cleared to the same degree.

COMMENT

It was found that if the side treated with the 1000 kv radiations received a total skin dose of approximately 25 per cent more roentgens, as measured, than the adjacent surface treated with the 200 kv radiations, then practically equal skin reactions developed—equal as to time of appearance, degree of erythema, extent of blistering and peeling, pigmentation, and subjective symptoms (Figs. 1 and 2). Doses that produce such similar reactions are obviously "biologically equivalent," no matter what the variation in physical units. To secure such biologically equivalent reactions not only must the final total skin dose, but also each fraction, be 25 per cent greater in roentgens. The distribution of the doses in days and the total elapsed time must be the same for the two qualities. Total (and fractional) skin doses greater than the above produced more marked 1000 kv reactions (Fig. 3) and those less, less marked reactions (Fig. 4).

It is shown that the dose in roentgens as measured in air cannot be used as a measure of comparison because the amount of backscatter, which also affects the skin, is so different for the two qualities (Chart 1). A much greater increase than 25 per cent in the number of roentgens as measured in air is required of 1000 kv radiations because of the decreased backscatter. Nor can the dose in roentgens as measured on the skin be used because it does not take into consideration the exit dose which is much greater for the 1000 kv quality. The exit dose varies with the size of the field used and the thickness of the patient and, therefore, varies from patient to patient (Chart 2). Those radiologists who have given the same fractional dose as measured in air, of higher voltage radiations as of 200 kv radiations, were actually giving considerably smaller skin doses and, therefore, should not have expected similar skin reactions even though prolonging the treatments so as to give more roentgens in the total dose.

Since the depth dose is a percentage of the skin dose, and not of the air dose, similar air r doses result in lower depth doses of 1000 kv radiations and, therefore, less diarrhea results. It is hard to believe that with less reaction on the bowel there can be more reaction in the adjacent tumor.

The difference in the number of roentgens, as measured by a thimble chamber, required to pro-

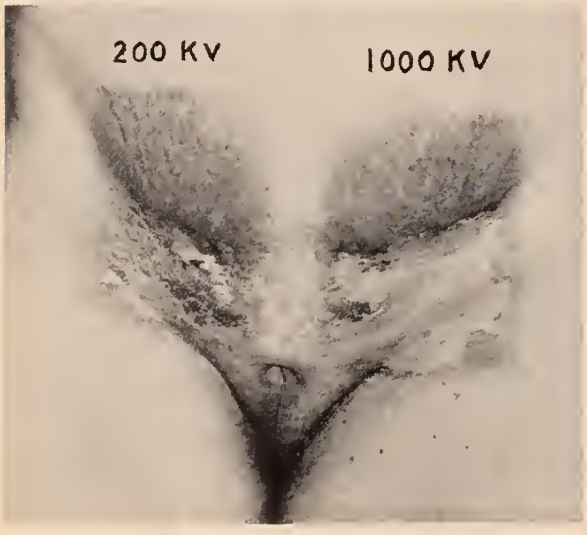

Fig. 3

Fig. 3.—G. T. (see table 4). A stage in evolution of *greater* skin reaction on *left* (1000 kv). 33 per cent more roentgens in total skin dose on left. 52 days after start, 23 days after end. More rapid development and progress on left. Compare figures 3 and 4 with figures 1 to 3 which show equal reaction when 25 per cent more roentgens were present in total skin dose on left side (1000 kv).

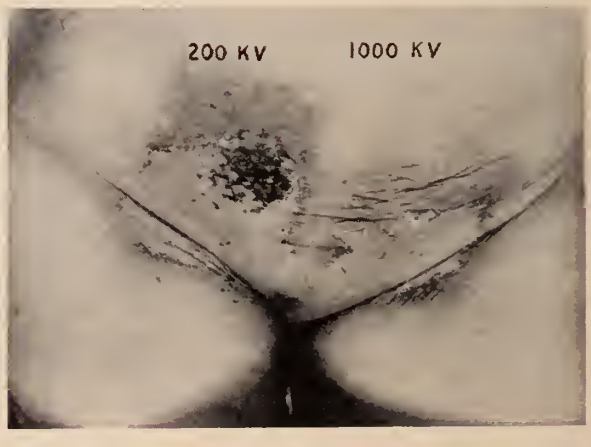

Fig. 4

Fig. 4.—L. G. (see Table 3). A stage in evolution of *greater* skin reaction on *right* (200 kv). Only 12 per cent more roentgens in total skin dose on left (1000 kv). 51 days after start, 17 days after end. Right-sided reaction developed sooner, more severe.

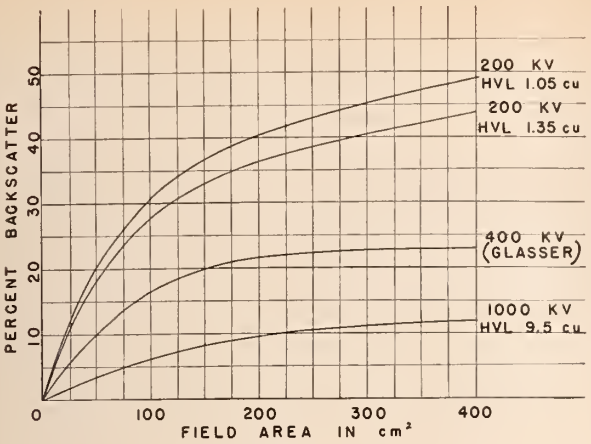

Chart 1

Chart 1.—Curves of percentage backscatter for various voltages and field sizes.

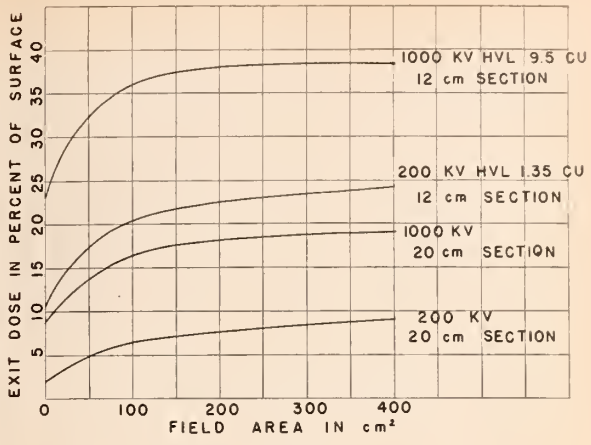

Chart 2

Chart 2.—Curves of exit doses for phantoms 12 and 20 cm. thick.

duce biologically equivalent skin reactions with the two qualities of radiations, is the same as that found by Packard using Drosophila eggs.

The explanation of the 25 per cent differential is not clear. The thimble chamber measurements may not be accurate at both voltages. The energy value of the roentgen is said to be lower at the higher voltages. The fact that the skin reactions were so similar would seem to eliminate a differential wavelength effect.

TABLE 2.—*Group 1: Skin Reactions—Similar*

Patients given approximately 23 per cent more total skin dose (air r + backscatter + exit dose) on left with 1,000 kv radiation than on right with 200 kv radiation. Measurements made with Victoreen condenser r meter. The color photographs showed that in this group the skin reactions to the two qualities were essentially similar. Per cent doses are 1,000 kv doses as per cent of 200 kv doses. All fields 10 x 15 centimeters in size.

Pt.	Thick Centimeter	No. Tr. Each Field	Elapsed Days	Total r Air		Air r Per Cent	Total r with Backscatter		r Skin Per Cent	Total Skin Dose		Total Skin Per Cent
				200 kv	1,000 kv		200 kv	1,000 kv		200 kv	1,000 kv	
E. B.	14	12	27	2,300	3,125	136	3,128	3,406	109	3,660	4,462	122
E. C.	14	12	29	2,300	3,162	137	3,128	3,446	110	3,660	4,515	123
S. H.	14	14	32	2,300	3,125	136	3,128	3,406	109	3,660	4,462	122
M. R.	16	12	27	2,300	3,162	137	3,128	3,446	110	3,503	4,308	123
A. A.	16	12	29	2,300	3,162	137	3,128	3,446	110	3,503	4,308	123
J. M.	15	12	30	2,300	3,125	136	3,128	3,406	109	3,565	4,360	122
C. M.	15	12	30	2,300	3,125	136	3,128	3,406	109	3,565	4,360	122

TABLE 3.—*Skin Reactions—200 kv More Marked*

Group 2. Patients given approximately 10 per cent more total skin dose (but almost equal doses as measured on skin without exit dose) on left with 1,000 kv radiation than on right with 200 kv. Color photographs showed somewhat more severe reactions to 200 kv.

Group 3. Patients given approximately same dose as measured by roentgens in air on both sides. This calculates to 15 per cent less total skin dose on left (1,000 kv) than on right (200 kv). Color photographs showed very much more severe skin reactions to 200 kv radiation. Per cent doses are 1,000 kv doses as per cent of 200 kv doses. Fields 10 by 15 centimeters except J. R., 10 by 20 centimeters.

Pt.	Thick Centimeter	No. Tr. Each Field	Elapsed Days	Total r Air		Air r Per Cent	Total r with Backscatter		r Skin Per Cent	Total Skin Dose		Total Skin Per Cent
				200 kv	1,000 kv		200 kv	1,000 kv		200 kv	1,000 kv	
GROUP 2												
M. S.	16	13	31	2,479	3,016	122	3,383	3,288	97	3,823	4,110	107
L. G.	16	14	33	2,635	3,333	126	3,584	3,633	101	4,050	4,541	112
J. R.	18	15	36	2,900	3,623	125	4,060	3,985	100	4,466	4,862	109
GROUP 3												
H. C.	18	16	40	3,627	3,550	98	4,951	3,862	78	5,446	4,636	85
E. S.	20	14	32	3,159	3,090	98	4,283	3,362	79	4,612	3,943	85

TABLE 4.—*Group 4: Skin Reactions—1,000 kv Slightly More Marked*

Patients given approximately 30 per cent more total skin dose (air r + backscatter + exit dose) on left with 1,000 kv radiation than on right with 200 kv. Color photographs showed more severe reactions of varying degrees on side treated with 1,000 kv. Per cent doses are 1,000 kv doses as per cent of 200 kv doses. All fields 10 x 15 centimeters in size.

Pt.	Thick Centimeter	No. Tr. Each Field	Elapsed Days	Total r Air		Air r Per Cent	Total r with Backscatter		r Skin Per Cent	Total Skin Dose		Total Skin Per Cent
				200 kv	1,000 kv		200 kv	1,000 kv		200 kv	1,000 kv	
M. M.	20	13	32	2,500	3,700	148	3,400	4,033	119	3,655	4,719	129
I. S.	18	13	33	2,500	3,700	148	3,400	4,033	119	3,740	4,840	130
L. S.	16	13	33	2,500	3,700	148	3,400	4,033	119	3,808	5,051	133
E. F.	19	11	36	2,100	3,100	148	2,856	3,379	119	3,113	4,021	129
G. T.	16	13	29	2,500	3,700	148	3,400	4,033	119	3,808	5,051	133
E. N.	17	13	33	2,500	3,700	148	3,400	4,033	119	3,797	5,013	132

It would seem that if radiologists are interested in biological effect, rather than in giving a certain number of roentgens, they should cease making the loose statement that bigger doses of so-called supervoltage radiation can be given with less skin effect. What is really meant by such a statement is that it takes a greater number of "roentgens," as measured by a thimble chamber, to produce the same effect. *If it takes more "roentgens" to produce the same effect on the skin, is it not likely that it would take more "roentgens" to produce the same effect on the tumor?* It is false and misleading, both to the laity and to other physicians and surgeons, to speak of "bigger doses." We should use the term "biologically equivalent" doses until the physicists provide us with a truly comparative measure to use on the various voltage radiations.

We are not here concerned with the advantages or disadvantages of one or the other types of radiation. Our aim has been the demonstration that similar skin reactions will be produced by widely different qualities of radiation if biologically comparable methods of treatment are employed.

CONCLUSIONS

1. Similar skin reactions can be produced by 200 kv and 1000 kv radiations on opposite sides of the abdomen of the same patient.

2. The similarity includes: (1) Time of appearance; (2) Degree of erythema; (3) Extent of blistering and peeling; (4) Degree of pigmentation; (5) Subjective symptoms.

3. The physical doses, as measured by a thimble chamber, are not the same. It required approximately 25 per cent more roentgens in the "total skin dose" of the 1000 kv radiations.

4. To produce these similar reactions the fractional doses, as well as the total doses, must be "biologically equivalent."

5. The distribution of the dose in days, and the total elapsed time must also be the same.

6. The difference in the number of roentgens, as measured by a thimble chamber, required to produce "biologically equivalent" skin reactions with the two qualities of radiation, is approximately the same as that found by Packard using Drosophila eggs.

7. "Biologically equivalent" doses, merely because they require a greater number of "roentgens" of higher voltage radiations, should not be described as "bigger doses."

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USE OF THE "BLOOD BANK" IN TRANSFUSIONS*

By NEWTON EVANS, M. D.
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BLOOD transfusion is one of the outstanding accomplishments of modern scientific medicine. It became possible through the discovery of the blood groups by Landsteiner in 1900. The multiple syringe method is probably the best method for direct transfer of fresh blood. The indirect citrate method has largely supplanted direct methods, because of its ease and simplicity. At the Los Angeles County Hospital the citrate (indirect) method has been the routine procedure for about ten years. At the Mayo Clinic the citrate method has been routinely used for more than twenty years.

While the use of refrigerated blood was introduced during the World War (1918), that method attracted little attention in this country till about three years ago. In July, 1937, Fantus of Cook County Hospital published in *The Journal of the American Medical Association* a description of their "blood bank." It was called a "bank" because the refrigeration storage system necessitated a plan for deposit and withdrawal of blood analogous to the depositing of funds in a bank for the establish-

* Read before the Section on General Surgery at the sixty-ninth annual session of the California Medical Association, Coronado, May 6-9, 1940.

ment of a credit balance, against which the creditor might draw.

PLAN AT LOS ANGELES COUNTY GENERAL HOSPITAL

At the Los Angeles County General Hospital the plan appeared attractive, and the practicability of utilizing it was studied. It offered three distinct advantages.

1. It would save precious time in emergencies where haste was necessary to save lives, and where the old system of finding a suitable donor, involving the necessary tests, including compatibility tests and serologic tests for syphilis, and the collecting of the blood, often proved too time-consuming.

2. It would prevent the all too frequent accident of giving blood from a donor who was later proved, by the routine Wassermann and Kahn tests, to be Wassermann-positive, notwithstanding the fact that the preliminary emergency serology test (Kline test) appeared to be negative. It is a well-recognized fact that there is a definite, irreducible minimum of disagreement between the Wassermann complement-fixation test and the flocculation test. Under the blood bank system it would be possible to test all blood used, by routine methods, and avoid using any such questionable bloods.

3. It would make possible the saving of many thousands of dollars which were being spent for professional or paid donors.

All three of these expectations have been realized by actual experience with the stored blood method.

ARMAMENTARIUM

The equipment, including chiefly a large refrigerator with suitable drawers for the various types of blood in the different stages of sterility and serology tests, was provided. The necessary forms and rules of procedure were established. In January, 1938, the method was begun routinely, and by the end of the second year, January, 1940, about 8,500 transfusions had been given with refrigerated blood. This would be an average of about twelve transfusions daily. With this large volume of blood deposited and withdrawn daily, it has been found that there is very little blood lost by becoming too old for use. The present rule is to use no blood which has been in storage longer than seven days. The types of blood accepted are, of course, chiefly type 4 and type 2, since these constitute the great majority of both donors and patients, and since type 4 (the universal donor type) is used freely for patients of any of the four groups. The use of type 4 blood for patients of the other groups is not the rule followed in many clinics where only donors of the same type as the patient are used.

It is obvious that the blood bank could not be successfully used in any but larger hospitals, where the turnover is rapid.

TIME LIMIT ON BLOOD STORAGE

The changes in the red cells of the stored blood determine the time limits for its use. In the original report from Cook County Hospital, the statement was made that the blood could be used up to "three or four weeks." In July, 1938, a year later, they had reduced the time to "ten days." In our hospital, at first the blood was used up to ten days. Experience led us to reduce this to seven days. When blood is kept longer than this, some of the cells begin to hemolyze. The most dependable experimental observations dealing with this point with which I am acquainted were published by Wiener and Schaeffer last October. Doctor Wiener of Brooklyn is the well-known authority on blood typing, whose book is widely used and regarded as authoritative. He noted three facts:

1. That if blood stored in citrate solution were used later than seven or eight days the transfused cells disappeared from the recipient's blood at a much faster rate than if fresh blood were used, or blood stored for less than eight days.

2. That blood transfused later than the seventh or eighth day produced a detectable hemoglobinemia, as determined by colorimeter tests.

3. That if the older blood were used an actual hemolytic jaundice could be detected in the recipient.

It is recognized, both from clinical observation and animal experimentation, that such hemoglobinemia is injurious, particularly to the kidneys.

ANTICOAGULANT PRESERVING FLUID

Sodium citrate solution, 2.5 per cent in physiologic saline, is the usual solution employed. At Cook County Hospital, for preserving 500 cubic centimeters of blood, 70 cubic centimeters of 2.5 per cent citrate is used; but when the blood is transfused, another equal amount of saline solution is added, so that the blood is actually diluted to more than double its original volume. At the Los Angeles County General Hospital, 250 cubic centimeters of .7 per cent sodium citrate is used. One important advantage of this technique is that, with this larger amount of fluid when the blood is allowed to flow into the diluting fluid from the donor's vein, practically no agitation of the container is necessary to prevent clotting of the blood, which is not true if the smaller amount of diluting fluid is used.

Considerable experimental work with different diluting fluids has been reported, notably that of DeGowin (and coworkers) at the University of Iowa. They have arrived at the routine plan of using 750 cubic centimeters of a dextrose and sodium citrate solution for 500 cubic centimeters of blood. Such a mixture will protect the blood against hemolysis to such a remarkable degree that the blood may be kept in the refrigerator for periods up to thirty days and is still usable. Such a method evidently presents marked advantages for small hospitals where a slower turnover obtains.

OPTIMUM TEMPERATURE FOR REFRIGERATION

For the two years that our refrigerator has been operating, it has been kept at 5 degrees centigrade (4 to 6 degrees). According to reports from Cook County Hospital, they originally used a 5 degree

average temperature, but more recently they have changed to 2 degrees, with a maximum of 4 degrees. DeGowin states they use a temperature of 5 degrees centigrade.

We have recently adopted a plan suggested by DeGowin, of refrigerating the diluting fluid in its container, prior to drawing the blood from the vein into the fluid. He observed a definite superiority of blood rapidly chilled in this way in the feature of less rapid hemolysis.

Another observation of DeGowin seems to be of considerable importance, namely, that it is unnecessary to heat the blood to body temperature just before the transfusion begins. He has followed this plan in several hundred cases without any evident untoward effects.

LABORATORY TESTS

The use of stored blood makes it possible to carry on the essential routine laboratory tests with accuracy and deliberation. These tests include:

1. Determination of the type of blood, whether it is O, A, B, or AB type, according to the Landsteiner terminology.

2. Cross-matching with the blood of the patient just prior to its use. Rather surprisingly, at the Mayo Clinic it is routine procedure to omit this cross-matching, depending entirely on the independent typing of the donor's and the patient's blood, to determine the compatibility. We feel that the additional safeguard of cross-matching is worth the trouble in giving added confidence in its compatibility.

3. Testing the blood for bacteriologic sterility.

4. Making the serologic tests for syphilis. In our laboratory, for years these have included the Wassermann complement-fixation test (Kolmer modification) and the Kahn flocculation test.

TRANSFUSION REACTIONS

Occasional untoward reactions accompany or follow the introduction of the blood. The symptoms constituting such reactions include pain in the back or chest, dyspnea, chills and fever, flushing of the face, signs of shock, nausea and vomiting, and, occasionally, later evidences of hemolysis, with hemoglobinemia and oliguria or complete renal failure with anuria.

The factors responsible and the mode of their action are not entirely clear. They include (1) those relating to the patient's own condition, as in fevers and infections, and allergic reaction; (2) technical factors, such as lack of complete clinical and bacterial cleanliness; (3) and the most important, probably, those concerned with the use of incompatible blood, such as occurs when a mistake is made in the type of blood used. Probably more often an incompatibility exists when a blood is used which contains a so-called subgroup A_2 agglutinogen, which is unrecognized and is not readily detectable by the routine typing methods.

Statements from the Cook County Hospital apparently minimize the importance of transfusion reactions. Other data from carefully supervised transfusion services would indicate that approximately 10 per cent of transfusions are accompanied by reactions of a definite grade of severity. DeGowin of Iowa City frankly reports thirteen untoward reactions of what he calls a "grave" nature in 3,500 transfusions. Of these thirteen cases, seven ended fatally, five had serious renal insufficiency, and two, pulmonary edema. In the past two years at the Los Angeles County General Hospital there have occurred at least one or two deaths which were probably due to renal failure incident to severe hemolysis. In these cases it was shown, by later rechecking the typing and the cross-matching, that no mistakes had been made in the typing of the blood used.

The chief technical errors which may be responsible for reactions, aside from the typing difficulties just mentioned, are lack of cleanliness in the tubing and other equipment and the effects of the so-called "pyrogens," that being the name given to certain bacteria which are known to grow in the distilled water that is used for the preparation of the citrate solutions. This can be controlled by the immediate sterilization and protection from the air of the distilled water. All of this work is successfully done in the manufacturing department of the pharmacy at the County Hospital, where the anticoagulant solutions are prepared and sealed.

The only published comparison of the incidence of reactions in transfusions with refrigerated blood and immediate citrate transfusions is from the Mayo Clinic. In Rochester, they are gradually coming to use more and more the refrigerated blood, and their data for the past two or three years show a definite advantage of the refrigerated blood over the immediate transfusions in the incidence of reaction, as will be seen by a lantern slide which I plan to put on shortly.

Considerable doubt exists regarding the innocuousness of using type 4 blood in patients belonging to one of the other three groups. I shall exhibit a lantern slide which shows statistically that no more reactions occur in this combination than when homologous groups are exclusively used.

OTHER CHANGES IN STORED BLOOD

It has been pointed out that certain chemical and biological changes occur in stored blood, and the importance of the dissolution of the red cells has been discussed above. Although no materially significant hemolysis occurs in the bank blood during the first seven days, other changes do occur, including the dissolution of some of the leukocytes and of the blood platelets, as well as a marked drop in the prothrombin, and the blood sugar. Another feature to which considerable attention has been given is the passage of the potassium ions from the red cells into the blood plasma. This last item, according to the best information now available, is of no practical significance.

It seems evident, however, that a marked reduction in the leukocytes and platelets does lessen the value of the blood in conditions where these elements are needed, as in the thrombocytopenic purpuras and the agranulocytic anginas and aplastic

anemias. It is also obvious that in efforts to combat the hemorrhagic tendencies in jaundice, blood with reduced content of prothrombin would have less value than fresh blood. However, it is probably true that the use of vitamin K and related substances is much the most effective means of combating these conditions, rather than by transfusions.

INDICATIONS FOR TRANSFUSIONS

The chief indications for transfusions of whole blood are acute hemorrhages, severe secondary anemias due to hemorrhages and other causes, and shock. It is probable that altogether too many transfusions are given in our hospital, as well as in other places, on insufficient grounds. Serious question exists regarding the wisdom of transfusions for sepsis and infections. Bates* of Northwestern University not long ago presented data indicating that transfusion for septic conditions and in leukemias are useless and sometimes even dangerous.

Transfusions in the condition of dehydration often seen after extensive burns deserves some discussion. In the nature of the process there results a loss of tissue fluids and blood plasma with blood condensation, and a relative red cell increase, which would seem to be best corrected by the administration of blood plasma without the red cells. Some reports of clinical observations confirm this view.

A somewhat similar condition exists in many cases of secondary shock without hemorrhage. It appears logical that the intravenous administration of citrated blood plasma from which the cells have been removed by centrifugation will meet the indication for rapid blood volume increase. Recent clinical reports of a practical application of this method will support the view that it is a most effective life-saving procedure.

SUMMARY AND CONCLUSION

1. Use of stored refrigerated blood has certain definite advantages in a large hospital.

2. These include:

(*a*) Available blood for emergencies.

(*b*) Time for careful, deliberate performance of necessary laboratory tests.

(*c*) A marked financial saving.

3. Published data show that reactions are not more frequent than with the immediate use of citrated blood.

4. The use of type 4 blood (universal donor) does not result in more reactions than using homologous blood.

5. The stored blood is particularly useful in acute hemorrhage, secondary anemia, and in shock.

6. Blood transfusion is a therapeutic measure of great value, but it presents numerous problems which demand intensive investigation, particularly as to indications and contraindications, and the causes and prevention of untoward reactions.

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* S. G. & O., vol. 65, p. 545.

RELIEF OF PAIN ABOUT THE HEAD AND NECK*

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PAIN about the head and neck may result from a variety of pathological processes. Our present discussion will be confined to the various types of neuralgia and the intractable pain resulting from malignant disease in the cranial and cervical regions.

MAJOR TRIGEMINAL NEURALGIA

Most important, from the surgical standpoint, is major trigeminal neuralgia or tic douloureux. This condition is a distinct clinical entity, not to be confused with other neuralgias of the face described below. The character of the pain in tic douloureux is always the same and is diagnostic. It is sharp, jabbing and lightning-like, occurring in short paroxysms and stopping abruptly. Recurrent attacks may occur from minutes to hours apart, with complete relief between paroxysms. Often the patient wears an expression of apprehension and fear in anticipation of further suffering. The pain is usually unilateral and may involve any or all branches of the fifth nerve, tending to start in one branch and gradually to spread to the others. The commonest points of origin are in the second or maxillary division involving the infra-orbital region, and the third or mandibular division which includes the lower jaw and tongue. From either of these locations the pain may gradually spread to the first division, or ophthalmic branch, supplying the supra-orbital area, but it is seldom primary in this division.

The paroxysms are aggravated by chewing, talking, swallowing, or exposure of the face to cold air. Trigger points are not uncommon, and the slightest touch may initiate an attack of pain. These areas are often about the angles of the mouth, or alae of the nose, and may prevent washing of the face or shaving. Such patients present a pitiful picture of emaciation, exhaustion, and fear.

ETIOLOGY

The etiology of the disease is still obscure. Various theories—infection, sclerotic changes and others—have been advanced to account for tic douloureux, but none has been confirmed. The course is progressive, with gradual spread to other branches of the fifth nerve, but with occasional spontaneous remissions which may last for several months or even years. No findings are evident on objective examination. Trigeminal neuralgia is a disease usually appearing after the fourth decade, and rarely occurring before the age of thirty years. The average age is around fifty-five to sixty years, and males and females are about equally affected.

TREATMENT

The majority of patients undergo a variety of treatment, including extraction of teeth, operations

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on the nose, throat, and sinuses. None of these procedures is of the slightest value in the treatment of tic douloureux. Conservative measures may be tried. Trichlorethylene, used as an inhalant, may give temporary relief in some cases. More recently, improvement has been reported with the use of vitamin B_1, but there has been too little experience with this as yet to allow any positive statement as to its value or the duration of improvement. Alcohol injections or neurectomies of the peripheral branches of the fifth nerve give temporary relief for from six to eighteen months. Alcohol injections are confined largely to the second and third divisions and their branches. These procedures are highly technical, and are not entirely without risk of injury to near-by structures. They should be undertaken only by those highly conversant with such work.

Peripheral neurectomies on the supra-orbital, infra-orbital and inferior dental nerve may be done if the pain is confined to their distribution. All of these measures, however, are of temporary benefit only. The great majority of patients eventually require section of the sensory root of the gasserian ganglion which does not regenerate, so that this procedure results in permanent relief of pain. The operation is attended by a mortality rate of only about one per cent despite the advanced age and poor physical condition of many of these patients. Following section of the root, permanent anesthesia of the face results; at times paresthesias are present which are annoying, but in no way comparable to the previous pain. Section of the root is seldom done until previous alcohol injections have accustomed the patient to numbness about the face.

Certain refinements in technique have been brought about since Frazier originally sectioned the sensory root in 1901, as suggested by Spiller. Frazier later advocated sparing the motor root supplying the muscles of mastication, and subsequently spared the fibers of the ophthalmic division when pain did not involve this area. In this way it is possible to avoid anesthesia of the cornea, so that no special protection of the eye is necessary. More detailed differential section of the root to include only the fibers of the involved area was later suggested by Stookey. The operation is now performed with a straight incision inside the hairline through a small opening in the temporal bone, and the approach is entirely extradural. Dandy advocates approach through the posterior fossa, but the majority of surgeons prefer the subtemporal route. The facial nerve is not disturbed and, contrary to popular belief, facial paralysis is not to be expected. Occasionally transient facial weakness occurs a few days after operation because of injury about the superficial petrosal nerve, but gradually clears completely.

Sufferers from tic douloureux can be completely relieved of their pain and, if an early diagnosis is made, may avoid many unnecessary surgical procedures and be spared months or years of suffering.

GLOSSOPHARYNGEAL NEURALGIA

Glossopharyngeal neuralgia is also a distinct entity and is comparable to the major neuralgia of the fifth nerve (tic douloureux), but is less common. It was first described by Weisenberg in 1910, and is characterized by paroxysmal pain at the base of the tongue and in the tonsillar fossa, radiating to the region of the ear and occasionally into the neck. The attack of pain is short and is precipitated by swallowing, chewing, or touching the base of the tongue. The pain is sharp, stabbing, and stinging in character, and there is often a cough which occurs at the conclusion of a paroxysm. An accurate diagnosis can be made by cocainizing the tonsillar fossa, which will stop the pain as long as the cocain is effective. Treatment consists of intracranial section of the ninth nerve, which affords complete relief of pain without the production of unpleasant residual symptoms. The slight sensory loss in the palate and the unilateral loss of taste on the posterior portion of the tongue are of no consequence.

ATYPICAL FACIAL NEURALGIA

Atypical facial neuralgia, so called to differentiate it from tic douloureux, is not an uncommon condition. Much has been written about this condition, and it has been subdivided into a number of individual neuralgias, which will not be dealt with here. Their accurate identification in these subdivisions is difficult and often questionable, and the treatment of all is uniformly limited. The chief characteristic of atypical neuralgia of the face is that the pain is constant with exacerbations, in contrast with the paroxysmal type of pain occurring in tic douloureux. It is often described as a deep, aching, burning type of discomfort, and does not necessarily confine itself to the distribution of the fifth nerve. It may overlap into the occipital or cervical regions as well, and may be either unilateral or bilateral. The onset is likely to be rather abrupt without apparent etiological factor. In some instances the symptoms may develop in association with infection of the sinuses, and not infrequently they appear after dental extractions. The etiologic factor, however, is often entirely obscure, despite a careful search for and eradication of any possible foci of infection that might be contributing factors.

The treatment of these neuralgias presents a very difficult problem. They are often aggravated by operations on the nose or sinuses, or by repeated attacks upon a tooth socket or jaw bone after a dental extraction. Alcohol injections of nerve trunks or neurectomies are inadvisable, for they merely add an annoying anesthesia without relief of pain. Aside from the removal of obvious foci of infection, treatment should be of a conservative nature. An attempt should be made to build the physical reserve by general supportive measures, along both medical and dietary lines, as well as to divert the patient's mind, in so far as possible, from constant attention to his problem. Only occasionally have trichlorethylene inhalations appeared to be of help. The regular use of mild sedatives, such as phenobarbital, is helpful as a general measure. Very recently vitamin B_1 has been used in these neuralgias with some success. It is difficult as yet to evaluate its therapeutic value accurately, but the results in a limited number of cases have been encouraging. It would appear ad-

visable to employ it in large doses intravenously as well as by mouth.

CONVULSIVE TIC

Painful facial spasm or convulsive tic is a rather rare condition associated with severe paroxysms of facial pain accompanied by spasmodic contractions of the facial muscles. These may involve any part of the face, and care must be taken not to confuse this condition with tic douloureux. The etiology of convulsive tic is entirely unknown. Treatment is not particularly satisfactory; section of the fifth nerve gives no relief; section of the seventh nerve stops the facial spasm, but the pain may persist.

POSTHERPETIC NEURALGIA

Another very distressing condition, one of frequent occurrence, is postherpetic neuralgia. Herpes zoster may involve any of the branches of the trigeminal nerve, but the ophthalmic branch about the forehead and eye is most frequently affected. The pain is of constant burning character and may persist long after the eruptions have disappeared. It is not unusual for a patient to threaten suicide because of constant, intense pain.

In the acute stages, iodids may be helpful and, in some instances, the intravenous use of endoarson (containing iodin, arsenic, and phosphorus) will stop all pain when narcotics have been valueless. Injections of pituitrin also have been used with some success. According to some reports, diphtheria antitoxin has been used with relief of pain. On the other hand, these measures may afford very little relief in chronic postherpetic pain. Section of branches of the fifth nerve, or the sensory root itself, are valueless and are contraindicated. The use of vitamin B_1 is worthy of a trial, and x-ray therapy has been reported as giving occasional relief. Unfortunately, many of these patients are not benefited by any known measures of treatment.

PAIN IN MALIGNANT DISEASE

Malignant disease about the head and neck is often associated with severe and intractable pain. In many instances these conditions are not of a rapidly progressive nature, and patients may survive for several years. Pain, however, may make life unbearable, and the use of increasing amounts of narcotics is not only depressing but does not afford real relief.

Malignancies of the lip, tongue, cheek and accessory sinuses may produce severe pain in portions of the distribution of the fifth nerve. Interruption of the sensory fibers to the involved area will result in anesthesia and loss of pain. This may be accomplished by alcohol injections in localized lesions or by section of the sensory root of the fifth nerve if the pathological process is more widespread. Pain may extend beyond the limits of the fifth nerve, involving the palate, as in carcinoma of the tongue, or extending into the region supplied by the cervical nerve. Consequently, a careful analysis of the location and extent of the pain is essential before any procedure is undertaken. The ninth nerve supplying the palate may be sectioned intracranially and, at the same time, the upper cervical roots may be divided to relieve pain in their distribution.

Sjoquist recently described section of the bulbospinal tract of the fifth nerve for the relief of pain. The section is made intracranially in the brain stem and results in loss of pain and temperature sense on the homolateral side of the face, but allows preservation of the sense of touch. Sjoquist used this procedure in the treatment of tic douloureux, but it is equally applicable to the relief of the pain caused by malignancy. More important is the fact that section of the ninth nerve, the tract of the fifth nerve, and the upper cervical nerves can be combined in one operative procedure if pain is extensive. Otherwise it is necessary to section the fifth nerve through a subtemporal approach, and the other nerves by a suboccipital exposure. Following the production of anesthesia and the relief of pain, the local lesion may be excised or removed in so far as possible without anesthetic, overcoming some of the unsightliness to the patient and those about him.

These procedures are, of course, highly technical and are attended by some degree of risk. The patient's unrelenting pain must be taken into account, however, together with the prognosis of the malignancy. Such methods of treatment are really acts of mercy which the patient should have an opportunity to accept or refuse before resorting to the steady use of drugs. In any event, such therapy should be considered before the patient has become addicted to narcotics. The majority of patients prefer the surgery and its risk to the nightmare of a future without hope or comfort.

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APPENDICEAL CALCULUS

REPORT OF CASE

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ALTHOUGH foreign bodies in the lumen of the vermiform appendix are occasionally encountered, the presence of a true calculus visible by the roentgen ray is of rare occurrence. Appendoliths, which are nothing more than fecal concretions, are found with such frequency as to suggest a possible etiologic connection. Wangensteen and Bowers[1] found fecaliths in 80 per cent of their cases which terminated in gangrene and 44 per cent of the suppurative cases. However, it is not within the scope of this paper to discuss the rôle of concretions either in the etiology or the end-results of appendicitis.

Mitchell,[2] in an exhaustive review which appeared forty-one years ago, gives details of numerous case histories of the presence of many interesting objects found within the lumen of the appendix. Among the various objects which have been found were shot, pins, worms, teeth, gall-stones, bullets, fruit seeds, and many others. In many instances these patients showed no ill effects from the presence of these foreign bodies, and many were found accidentally at autopsy when death was due to

Fig. 1.—Note large amount of gas in bowels.

other causes. In this connection, Mitchell [2] quotes an interesting observation by Hevin in the Mémoires de l'académie Royale de Chirugie, 1743, 1, 460: "One notices sometimes in opening the bodies of persons who, during life have eaten a great deal of game, that there is collected in the intestines, and especially in the cecal appendix, a great quantity of shot, without these persons having had the least inconvenience."

In contradistinction to the ordinary fecalith and to foreign bodies which are accidentally ingested (of which there are many recorded cases), a true calculus or a calcified fecalith is extremely rare. Recent literature gives very few statistics on its frequency. Bunch and Adcock,[3] in a series of two thousand cases, have encountered it only on one occasion. It is probable that very few active surgeons have ever encountered such a case during their surgical experience. It is peculiar that such a large calculus as reported in this case, which necessarily must have been present for some time, should not have caused previous symptoms. Royster,[4] up until 1921, gives Packard [5] the credit of having removed the largest appendix stone on record, weighing eight grams and measuring 1 by 2 by 4 centimeters. This, however, is surpassed in size by the stone removed by Bunch and Adcock,[3] which weighed 13.5 grams and consisted essentially of calcium and magnesium phosphates.

DIAGNOSIS

A true calculus of the appendix is always visible by the roentgen ray, but because of its rarity its shadow is usually mistaken for the much more frequent ureteral calculus. If barium has been previously administered, a persistent residue in the appendix may coat the concretion and give a similar shadow. The passage of an opaque ureteral catheter will usually allow a differentiation. Douglas and LeWald [6] reported a case of a calcified fecal concretion which was found in the abscess cavity after the appendix had ruptured and which had been previously visualized by the roentgen ray.

Fig. 2.—Note position of calculus changed, also apparent large size of right kidney with lack of dye. Dye present in left kidney pelvis.

To illustrate the difficulty of diagnosing radio opaque concretions of the appendix preoperatively, Phahler and Stamm,[7] in 1915, stated that only one case had been diagnosed before operation, and that by Weisflog, in 1906, who found two stones in the appendix. However, since then there have been scattered reports of such concretions demonstrable by the roentgen ray. In many instances they have been found lying free in the peritoneal cavity, having escaped from a ruptured appendix. Case,[8] in 1916, reported two instances of concretions correctly diagnosed by the roentgen ray and confirmed at operation. Even with the use of the opaque ureteral catheter, mistakes in diagnoses are made, as attested by the similar cases of Seelig [9] and Eastmond.[10] In both instances the ureter was obstructed at the point of the suspicious shadow. The obstruction of the ureter was caused by an inflamed appendix adherent to the ureter, and the shadow in the roentgenogram was due to the concretion in the appendix in close proximity to the

Fig. 3.—X-ray film of appendix immediately after removal.

Fig. 4

Fig. 5

Fig. 4.—The calculus occupies the proximal half of the appendix.
Fig. 5.—Photograph of calculus measuring 2½ cm. in length. Note nodular appearance.

ureter. In such instances, a lateral roentgenogram with the opaque catheter in position will greatly aid in clearing up the diagnosis.

The following case is reported because of the paucity of reports in the literature, thus indicating the rarity of the condition, the large size of the calculus, the freedom of previous symptoms, the absence of advanced inflammatory changes in the appendix, and the bizarre clinical and roentgen findings which confused the clinical picture to such an extent that no suspicion was cast on the appendix as the offending organ.

REPORT OF CASE

W. L. W., white, married, male, age 38, and a farm laborer. For the past few years he has been a heavy drinker of alcohol and, except for occasional attacks of "sprained back," he has never been ill. He was first seen at 8 a. m. on April 22, 1940, complaining of severe pain in the right lumbar region, radiating to the right groin and across the upper abdomen. This condition came on suddenly eight hours before, during which time he vomited twice. Temperature was 98.2 Fahrenheit, pulse 82 per minute, and respirations 18 per minute.

Physical examination revealed a muscular, ruddy male, who was unable to lie still because of the severe pain. He was moderately tender over the right kidney, but the kidney could not be palpated. Palpation of the abdomen revealed moderate, guarded rigidity over the entire abdomen, but there were no areas of tenderness, although he said he felt "sore" over the entire upper abdomen. There was no frequency or dysuria and no hematuria was noted. He had taken two enemata during the night without relief. A diagnosis of right ureteral colic was made, and he was given 0.030 gram (one-half grain) of morphin sulphate hypodermically. He was again seen twelve hours later. He had obtained no relief from the previous hypodermic. Symptoms and physical findings were identical with the previous examination. There was no abdominal tenderness. The urine was normal except for an occasional pus cell. The blood picture at that time showed 94 per cent hemoglobin (Sahli), 4,600,000 red blood cells, and 6,200 white blood cells, with a normal differential count. He was again given 0.030 gram (one-half grain) of morphin hypodermically. When he was seen the next morning (thirty-two hours after the onset), he still had obtained no relief from the pain although he had taken five tablets of pantopon by mouth, each containing 0.020 gram (one-third grain).

Temperature was 99 degrees Fahrenheit, and pulse 78. The urine was normal and was negative for blood, both chemically and microscopically. He was still moderately tender over the right kidney, but at no time did he complain of pain or tenderness over the right lower quadrant. A plain x-ray (Fig. 1) was taken of the abdomen, and revealed a huge calculus in the right upper part of the true pelvis at the lower margin of the sacro-iliac joint. An enormous amount of gas was seen to distend the bowels. This latter finding was peculiar, as the patient's abdomen was almost scaphoid. The large amount of gas confused the diagnosis since, although the calculus had all the characteristics of a large ureteral stone, the possibility of a large calculus, probably a gall-stone, obstructing the bowel was taken into consideration. He was treated conservatively, and twenty-four hours later, following an enema and an injection of prostigmin, another plain film was taken. The roentgen findings were identical. His symptoms and physical findings were the same. Temperature was normal and urinalysis was entirely negative. Intravenous pyelography was then performed. Films taken five minutes after the injection of the dye showed the calculus in the same position, the right kidney seemed enlarged, and no dye could be seen in the right kidney pelvis, although dye showed in the left kidney pelvis. Another film (Fig. 2) was taken fifteen minutes after the injection of the dye. The dye was plainly visible in the left kidney pelvis. No dye could be seen in the right kidney pelvis, and the right kidney seemed greatly enlarged. A diagnosis of calculus of the lower third of the right ureter with hydronephrosis was made.

Because of the clear-cut findings of intravenous urography, it was not deemed necessary to perform retrograde catheterization of the right ureter. But as later events proved, such a procedure would probably have changed the diagnosis.

Operation.—Operation was performed fifty-six hours after the onset of symptoms, under spinal anesthesia. A midline surprapubic incision was made, the peritoneal fold was retracted upward, and the right ureter was exposed in its lower third. No calculus was found. The peritoneal cavity was then opened. The peritoneum itself and the intestines appeared normal. The appendix was easily brought out into the wound. It was lying free and the large size of its proximal end, together with its firm consistency, immediately revealed that the calculus was lying within the lumen of the appendix. The distal end of the appendix was firm but not acutely inflamed. The appendix was easily removed in the usual fashion. An x-ray film (Fig. 3) of the specimen, taken immediately, showed the identical calcified shadow as in the pictures taken preoperatively. The anterior abdominal wall was closed in the usual manner. Convalescence was uneventful, the patient leaving the hospital on the tenth postoperative day and returning to his usual occupation in six weeks.

Grossly, the entire proximal half of the appendix was filled by the calculus (Fig. 4). The serosa over the calculus was smooth and blanched, while in its distal half it contained a few dilated vessels. Nowhere was there any evidence of an acute inflammatory reaction. When the appendix was opened the entire wall around the calculus was greatly thickened and felt like cartilage. The stone was easily extracted and the mucosa throughout the entire organ was thickened, but normal.

The calculus (Fig. 5) measured 1 by 2 by 2½ centimeters and weighed 6.9 grams. The surface was grayish brown and was marked by many small nodules from pinhead to small pea in size.

CONCLUSIONS

1. From a search of the literature it appears that this is the third largest appendiceal calculus on record, being surpassed by that of Bunch and Adcock and that of Packard.

2. Possibility of extraureteral calculi must be considered in all calcified shadows in the region of the ureters.

3. Reliance on intravenous urography alone will frequently lead to erroneous conclusions, and all such suspicious shadows should have roentgenograms made in the lateral position, with the opaque ureteral catheter in place.

4. Foreign bodies may be present in the appendix for considerable time without causing acute inflammatory changes in that organ.

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OPERATIVE-SUPPORTIVE TREATMENT OF VARICOSE ULCERS*

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ALTHOUGH the treatment of varicose ulcer has received a great deal of attention from the profession, our experience has led us to believe that many physicians are not as yet fully acquainted with the methods for successful healing which are available, nor with the anatomical and physiological principles upon which these procedures are based. We still see, for example, the application of salves and antiseptic preparations to the ulcer, apparently on the assumption that the etiologic factor is infectious or inflammatory in nature. Moreover, we frequently find patients who have been insufficiently benefited by injection and surgical procedures which have been applied without a full realization of the principles involved. Indeed, at certain stages in the development of our own technique we have been guilty of some of these faults.

It is our purpose, therefore, to describe in this paper the anomalies which are responsible for ulcer formation and to present a type of therapy, designed to correct them, which has been quite successful in our hands. The methods are not original with us, except for certain individualized adaptations.

ETIOLOGY

The various theories of etiology will not be discussed here, since they have been described fully by others.[1-5] We wish only to point out, first, that the end-result is a valvular incompetence which is associated with reflux blood flow and an increase in the venous blood pressure in the superficial or deep venous systems; and, second, that the increase in venous pressure tends to reduce, and in certain circumstances actually to neutralize, the osmotic pressure of the blood colloids whose purpose is to draw tissue fluid into the venous capillaries. As a result, fluid is retained in the tissue spaces and may give rise either to localized edema, cell death, and ulcer formation, or to the diffuse edema, erythema, and scaly skin which has been called "varicose eczema." The incompetency most often seen involves the valve of the long saphenous vein located just distal to the sapheno-femoral junction. Incompetency may also be present in the short saphenous, or the thigh or lower leg perforator veins. Usually it is observed singly, although more than one vein may be involved. When this occurs it may be difficult, or even impossible, to discover all of the points of leakage. In such cases the treatment of the varices is raised from the level of a simple procedure to that of a complex diagnostic and therapeutic problem.

EXAMINATION

The patient is questioned for evidence of diabetes, thrombophlebitis (past or present), hereditary varicosis, and recurring ulceration. The state of the general and peripheral arterial circulation is studied, and the veins are tested for valvular incompetencies and for patency of the deep venous system. The former are determined by the multiple tourniquet method, and the latter by a modification of the von Perthe test. These procedures are well known and need not be described here.

TREATMENT

Successful treatment is directed toward correcting the defects in normal function. It comprises, first, the interruption of the reflux or "private circulation" in the superficial venous system; second, the obliteration of the long stretches of ineffectively valved, superficial venous channels; and, third, the rapid elimination of edema and induration. The first of these is accomplished by operation, the second by the injection of sclerosing solutions, and the third by proper support.

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Table 1.—*Nature of Cases and Results*

	Number of Cases	Average Size of Ulcer	Healing Time (Average)	Recurrences	
				Number	Per Cent
Thrombophlebitis	16	27 square centimeters	32 days	1	6.2
No thrombophlebitis	61	14 square centimeters	30 days	4	6.5

In general, the operative treatment consists of ligation of the incompetent perforator veins and their tributaries at the connection with the deep system. In the case of the long and short saphenous veins, this treatment includes, first, ligation and division of the affected vessel at its junction with the femoral or popliteal vein, respectively; second, ligation and division of all of the branches of the superficial vein within 3 to 4 centimeters of the anastomosis; and, third, excision of 5 to 10 centimeters of the proximal portion of the main superficial vein. This form of surgical treatment can be used in patients who have recovered completely from a femoral or iliac thrombophlebitis if incompetencies in the superficial veins are causing trouble and if the deep veins are patent.

Recently, Linton and Keeley[6] have added to our procedures a method for the ligation, at a single operation, of large numbers of the perforator veins of the medial or lateral side of the lower leg. It gives promise of yielding useful results, whenever the valves of these veins are incompetent.

Steps in Treatment.—The injection treatment comprises, first, a preliminary intravenous test of the sensitivity of the patient, with one-half cubic centimeter of the drug to be used; second, the introduction of from 2 to 4 cubic centimeters of a sclerosing solution* into the distal end of the long or short saphenous vein at the time of the operation by needle or ureteral catheter attached to the syringe; and, third, the occlusion of any remaining patent varices at subsequent office or clinic visits.

Supportive Treatment.—The supportive treatment is perhaps the most spectacular part of the entire procedure, and it is the one we wish to emphasize, since it is possible by this method alone rapidly to heal an ulcer which has persisted for months or years under the conventional treatment with salves, skin grafts, and so-called bed rest. It is particularly important because it allows the patient to be up and about, and often at work while the ulcer heals. As employed by us, it consists of the following steps: first, the judicious application of 10 per cent $AgNO_3$ to the skin and ulcer surface to control tinea; second, a covering of adhesive tape directly over the ulcer; third, a layer of cotton from toes to knee to protect the skin from irritation by the adhesive tape; fourth, a soft sponge rubber pad, one-quarter to one-half inch thick, over the ulcer and the surrounding indurated area; fifth, a gauze bandage wrapping to hold the cotton and sponge in place; sixth, a firm adhesive tape strapping.

The application of the adhesive support requires great care. Except in the presence of reduced arterial circulation it should be put over the ulcer, and the indurated and the edematous areas, with all the force at the command of the operator. Spectators have remarked that it is surprising the leg will stand the degree of pressure used. At the same time the tape must be applied smoothly and in such a manner that band-like compressions are not created over the dorsum of the foot or the Achilles tendon. The former is prevented by placing the adhesive obliquely across the foot while the foot is in marked dorsiflexion; the latter, by padding the tendon with cotton. The steps which are used in applying the adhesive tape are as follows: a circular band of three-inch tape is wrapped about the ankle a little above the malleoli with full force. This is the anchoring layer. Then a stirrup-like piece of three-inch tape is put around the sole of the foot and attached firmly on both sides to the anchor. A two-inch piece of adhesive is now placed distal to the anchor so as to overlap the latter by about one inch, with the loop around the Achilles tendon. With the foot in dorsiflexion the ends of the adhesive tape are then crossed obliquely and anteriorly over the dorsum. Three-inch adhesive is now applied firmly to the remainder of the dorsum and sole of the foot, as far as, but not covering, the first and fifth metatarsophalangeal joints. The encasement of the foot is not accomplished with the same force that is used on the leg, since the foot is rarely the seat of any edema. This procedure is intended to prevent swelling from developing in the foot as a result of the application of the strapping to the higher levels.

When the foot is covered, overlapping circular layers of three-inch adhesive tape are placed around the leg from the anchor to a point a little below the tibial tubercle. They are applied with full force. The top layer is attached to the skin for a width of about one inch above the top of the cotton layer. This holds the adhesive to the leg and prevents downward slipping. It is particularly important in persons with sloping lower legs.

Occasionally a patient's skin is so sensitive to adhesive that this support cannot be used even with the cotton protection. Under these circumstances two four-inch ACE bandages are used in place of the adhesive tape and are sewed together to prevent slipping.

At first the supportive dressing is changed two or three times weekly if the drainage is considerable. Then it may be changed only once weekly until the ulcer is well healed, and the skin becomes firm. Finally, a regimen of "decompression" is

* Author's Note.—All known types of sclerosing solutions have been tested by one of us (R. S. S.), including the salts, the sugars, sodium salicylate, quinin hydrochlorid, urethane, and the soaps. At present we prefer monolate (monoethanolamin oleate), sylnasol (sodium psylliate), and monoethanolamin morrhuate.

undertaken, which consists, first, of eliminating the sponge; second, of testing without support; third, of eliminating all support when possible or of substituting an elastic stocking if continued support is necessary.

The methods used are approximately the same whether the ulcer is associated with simple saphenous incompetence or with incompetence following a femoral thrombophlebitis, except that in the latter instance continuous support is the rule.

Occasionally, when the ulcer is large, pinch grafts are used to hasten healing. No change in the general treatment is necessary to insure a high percentage of "takes," except that the silver nitrate solution is withheld from the granulations, and the adhesive covering of the ulcer is applied carefully so as not to disturb the transplants.

RESULTS

Seventy-seven patients with ulcer have been treated during the past two years. Sixteen of these developed the lesion following a femoral thrombophlebitis. Two of the patients with saphenous-system ulcers had advanced arteriosclerotic obstruction in the leg vessels. They healed very satisfactorily. It should be noted, however, that much less pressure was used on these patients than on those whose arterial circulation was adequate. The table presents briefly the data on size of lesion, rate of healing, and recurrence. The recurrences were initiated by trauma to the skin over the healed ulcer. As a rule, a period of decompression of from two to four weeks was required. All of the patients with thrombophlebitic ulcers and several of those with simple saphenous vein ulcers required prolonged elastic stocking support because of persistent edema.

In general, the condition of the patients following the combined treatment gives promise of more lasting results than have been obtained by any other measures which we have used.

SUMMARY

1. Seventy-seven patients with varicose ulcer have been treated during the past two years with the combined operative-injective-supportive procedure.

2. The method has very materially improved the results in the care of varicose ulcers, and it permits the patient to be ambulatory.

3. The average rate of healing was from thirty to thirty-two days.

4. Some patients required prolonged support because of persistent edema.

5. When the case is properly selected and carefully treated, advanced arterial insufficiency is not a contraindication to the use of supportive therapy.

6. Sufficient time has not yet elapsed to permit a decisive opinion to be given concerning the long-term effects of this form of therapy, although the results which have been obtained are very favorable.

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RÔLE OF CAUDA EQUINA LESIONS IN THE PRODUCTION OF CONSTIPATION AND URINARY RETENTION*

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CONSTIPATION is difficult of definition but it is generally agreed that there should be one bulky and formed evacuation daily as a criterion of normal colonic function. We have looked upon constipation as of two varieties, (1) *atonic,* because of the presence of abnormal dilatation and redundancies of the colon often associated with large or absent haustrations and (2) *spastic,* because of the presence of an irritable colon, with spasm of some of its portions and often showing small, poorly developed and irregularly shaped haustrations. That both of these states have been cured by attention to the establishment of a proper diet, fluid intake, regular habits of eating and personal hygiene, and by regular and daily forms of exercise, no one will deny. However, since some of these cases are benefited by certain drugs, such as, the atropin group, phenobarbital, pituitrin, prostigmin and others, leads to the conclusion that a neurogenic factor is also involved in the production of constipation as these drugs act upon the sympathetic and parasympathetic extrinsic nerve supply to the colon and its sphincters. This effect of drugs may be on the nerve endings in the viscus, as for example atropin, or upon the higher autonomic centers in the hypothalamus, as illustrated by the effect of phenobarbital.

The neurogenic disturbance appears to be only functional in most of the cases of constipation but one may encounter other cases which suggest the possibility of a spinal cord lesion as being responsible for the constipation. The first evidence of this was furnished by Royle[1] in 1924, who announced a new operative procedure for the relief of spastic paralysis of the lower limbs consisting of ramisectomy of the white rami to lumbar sympathetic ganglia, following which he noted that certain of his patients were relieved of constipation.

Later Wade[2] designed an operation in which he cut, on the left side, the white rami to the first and second lumbar ganglia, as well as the visceral branches of the lumbar sympathetic chain, and finally severed the sympathetic trunk below the

* Read before the Section on Neuropsychiatry at the sixty-ninth annual session of the California Medical Association, Coronado, May 6-9, 1940.

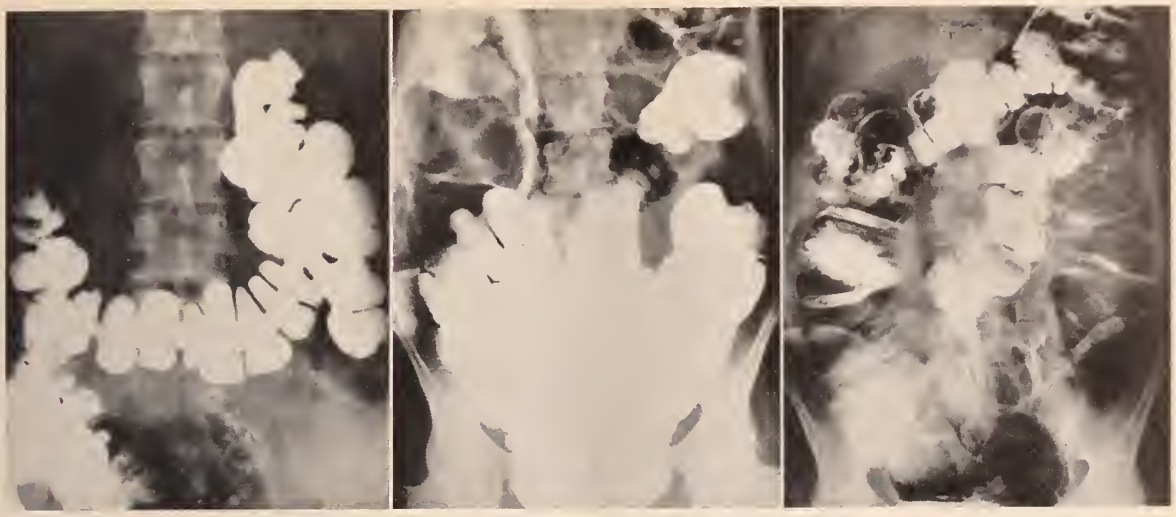

Fig. 1 Fig. 2 Fig. 3

Fig. 1.—Barium filled colon in 1934, showing essentially a normal colon.
Fig. 2.—Barium enema on March 17, 1939, revealing large loops of megacolon.
Fig. 3.—Twenty-four hours after barium enema on March 17, 1939, showing megacolon and redundancies.

fourth lumbar ganglion. This operation was performed on cases of idiopathic megacolon, or Hirschsprung's disease, with remarkable improvement in bowel function and disappearance of stubborn constipation. Thus, proof was given that dilatation of the colon with constipation appeared to be due to an overbalance or domination of the sympathetic nerve supply to the colon.

NEURO-ANATOMY

On this occasion, there is insufficient time to describe the autonomic extrinsic nerve supply to the colon, bladder and reproductive organs, but one may refer to a paper by Trumble[3] and others quoted in this paper for a complete description and presentation of the neuro-anatomy of the lower abdominal viscera.

PHYSIOLOGY

The action of the sympathetic and parasympathetic nerve supply is diametrically opposite in character. When the sympathetic nerves are stimulated, a contraction of the sphincters of the rectum and bladder and a dilatation of the walls of these organs take place. If the parasympathetic nerves are stimulated, an opposite effect occurs, *i. e.*, relaxation of the sphincters and a contraction of the walls. The action of the sympathetics is "filling" and that of the parasympathetics is "emptying." Both of these systems have their fibers ending in the muscular wall of each viscus, and in the case of the colon they end in Auerbach's plexuses without which peristalsis could not occur. Some fibers end in Meissner's plexuses which lie in the submucosa and control the mucous secretion of the bowel.

In regard to the reproductive organs of the female, it is stated that stimulation of the sympathetic fibers causes the contraction of the fibers of the cervix (internal os) and relaxation of the uterine walls; whereas, the parasympathetics when stimulated cause relaxation of the sphincteric action of the cervix and contraction of the uterine body muscles. Again, we note the "filling" or retention action of the sympathetics and the detrusor or "emptying" action of the parasympathetics, as in the bladder and rectum.

The sympathetic nerve supply is also responsible for vasoconstriction of the blood vessels of the internal pelvic organs as well as the extremities and for activation of the sweat glands. Their excision results in increased blood supply to the pelvic viscera and increased warmth and dryness of the feet from vasodilatation and inhibition of the sweat glands.

PATHOPHYSIOLOGY

In a healthy individual enjoying normal bowel and bladder function, and if a female without primary dysmenorrhea, a balance in function is believed to be maintained between the action of the sympathetic and the parasympathetic fibers. There are, however, individuals in whom this balance is upset, and abnormal or pathophysiologic reflexes occur which produce abnormal physiologic states with resultant functional disturbances in the pelvic viscera.

Certain disturbances of bladder and colon function may be considered together because of their frequent association, and because of their identical autonomic nerve supply.

The lumbar sympathetic fibers are responsible for the "filling" or retention action of both these viscera, while the sacral parsympathetic fibers cause the "emptying" of these organs. Therefore, an unusual dilatation of the colon and bladder, producing chronic constipation and urinary retention, may be looked upon as due to either (*a*) constant stimulation of the sympathetic fibers or (*b*) decreased action of the parasympathetic system. The net result being an overbalance or domination of the lumbar sympathetic nerve supply. When the reverse state of disturbance occurs, producing diarrhea, in the absence of any intrinsic gastrointestinal pathology, and frequency of urination, a domination of parasympathetic action may be

Fig. 4*a*

Fig. 4*b*

Fig. 5

Fig. 4.—(*a*) Filling defect in cul-de-sac after lipiodol injection in the spinal canal; (*b*) with patient in Trendelenburg position, showing retention of the oil in the cul-de-sac.

Fig. 5.—Cystic mass with fibro-areolar tissue removed from cul-de-sac.

hypothecated, but such cases are not as yet clinically differentiated unless, as I believe, some cases of so-called neurogenic diarrhea and urinary frequency represent such examples. Such cases, however, appear to represent a disturbance in the activity of the higher autonomic centers in the hypothalamus. However, in man there are well-recognized instances of bladder and colonic disturbance that are due to an overbalance of sympathetic action and many of them, with the probable exception of Hirschsprung's disease, appear to be explained upon a decrease in parasympathetic action due to some lesion of the conus or cauda equina, which follows either trauma, infection, congenital defect, or pressure exerted by fibrous, cartilaginous or bony structures and tumors.

MEGACOLON AND CONSTIPATION

Cases of megacolon with constipation, whether of the congenital or acquired type, associated with or without atony of the bladder, producing urinary retention, are the clinical conditions that are believed due to a domination of lumbar sympathetic action. That this is true seems substantiated by the success of lumbar sympathectomy, for constipation is improved or cured, the urinary retention also disappears, and the colon and bladder tend to return to normal size.

Most cases of lumbar sympathectomy have been done on cases of congenital megacolon, known as Hirschsprung's disease, and the results have been very successful, but it is not necessary here to review the many contributions which have definitely established that lumbar sympathectomy is the indicated operation in all cases of Hirschsprung's disease.

The success of the operation in cases of Hirschsprung's disease led to its trial in cases of acquired megacolon which are usually encountered in middle-aged people, as compared with congenital megacolon which appears almost exclusively in children. Many of the cases of acquired megacolon received as much benefit from the operation as did the congenital cases, while others were somewhat improved and some none at all.

Rankin and Learmonth [4] reported improvement in their cases of acquired megacolon, but not as remarkable as in the congenital cases operated upon. Ross [5] reported seven failures out of fifteen cases of acquired megacolon so operated. Gask and Ross [6] reported three out of twelve cases operated upon for acquired megacolon as cured, improvement occurred in three others, but six received no benefit.

It should be stated for the sake of fairness of statistics that all these cases reported did not have much dilatation (megacolon), but only constipation. Gask and Ross substantiated the earlier observation of Wade, that unless dilatation of the colon is a prominent feature in the cases of constipation, lumbar sympathectomy is apt not to be a success in establishing normal colonic function. In these cases any tendency to urinary retention is also corrected.

As a guide, therefore, in the selection of cases of constipation for which lumbar sympathectomy is indicated, there must be definite evidence of megacolon established by x-ray investigation, if one wishes to have success in curing constipation and the return of the colon to almost its normal size.

ATONIC BLADDER AND URINARY RETENTION

Urinary retention, according to Adamson and Aird,[7] is associated with megacolon in 5 per cent of the cases: But they believe that the evidence of association is much higher since most investigators of megacolon do not make any urological study for

residual urine. It might also be said that many cases of cord bladder occur and no study is made to learn if a megacolon exists, even though the patient complains of stubborn constipation.

These cases of cord bladder, occurring alone or associated with megacolon, may, as already stated, result from a lesion of the cauda equina, causing overbalance of the sympathetic nerve supply to the bladder, and its excision by lumbar sympathectomy restores normal bladder function.

Learmonth,[8] in 1931, reported two such cases, with very good results, from resection of the presacral plexus. Later Adson,[9] in 1933, reported success in six out of eight cases, and Foulds,[10] Bailey,[11] Fulcher,[12] and Abbott[13] have reported similar successes.

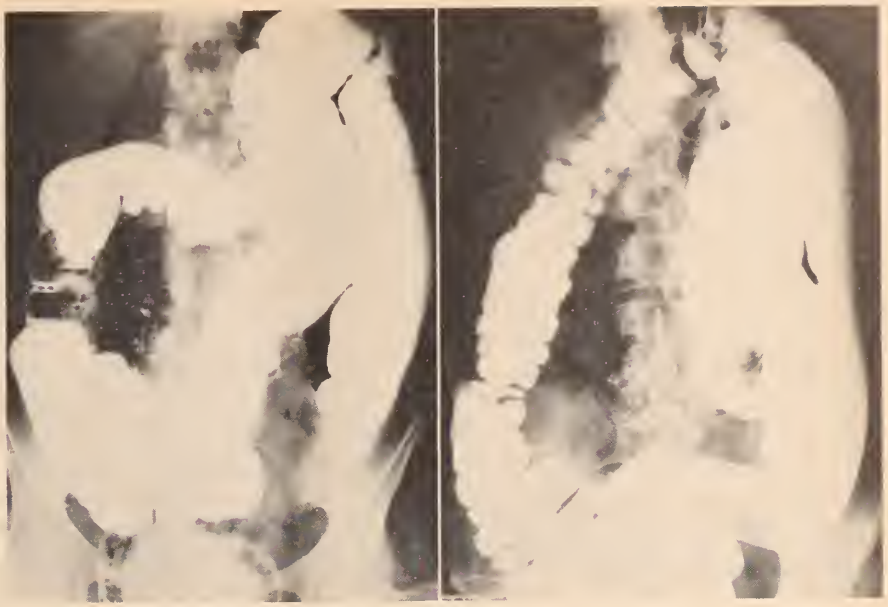

Fig. 6 Fig. 7

Fig. 6.—X-ray of colon on December 9, 1939, after barium enema, showing decrease in calibre and length, and presence of long redundancy of the sigmoid.

Fig. 7.—X-ray of colon on April 8, 1940, nine months after lumbar sympathectomy, showing absence of long redundant sigmoid, normal calibre, but redundant loop of descending colon.

According to Learmonth, sympathectomy for the relief of cord bladder, producing urinary retention, is indicated when the four following conditions are present:

1. Clinical data must point to a reduction of the function of the parasympathetic nerves, while there must be no injury of the sympathetic (presacral) nerves.

2. There must not be total paralysis of the parasympathetic nerves, in order that after removal of the sympathetic supply the residual emptying power of the detrusor muscle may be more equal than before to emptying the bladder.

3. The patient must be continent, through the action of the external sphincter muscle (supplied by the pudendal nerve) as the presacral nerves are the motor nerves to the internal sphincter.

4. Finally, there must be satisfactory renal function.

Therefore, these conditions for the bladder, together with that of dilatation for the colon, should govern one in his selection of cases that may have their constipation and urinary retention either cured or greatly improved by the operation of lumbar sympathectomy.

Since these cases are not very common, it seems worth while to present such a case in which these conditions were present, which were produced by a lesion in the conus; a lumbar sympathectomy restored normal function, to both the colon and the bladder, and the colon returned to almost its former normal size.

Case History.—A white female, 42, a school teacher, suffered from stubborn constipation, requiring daily enemas and laxatives for relief. In 1934, an x-ray of the colon was essentially normal. Marked abdominal distention, with obstructive symptoms, often occurred. She was brought to the hospital on March 13, 1939, by Dr. Conrad Baumgartner of Los Angeles, for obstruction, which, however, responded to enemas after two days of treatment. X-ray on March 17, 1939, revealed a megacolon and no organic obstructive lesion.

I saw the patient on March 21, 1939, and urinary retention was also discovered—as much as 1,300 cubic centimeters of residual urine was found. Cystoscopic examination revealed a large atonic bladder and normal sensation. A lesion of the cauda equina, producing impairment of the parasympathetic nerve supply to the colon and bladder was hypothecated. A neurological and spinal fluid examination by Dr. John B. Doyle, revealed nothing abnormal, but he recommended lumbar sympathectomy to help, or cure the constipation and urinary retention. On June 26, 1939, Dr. R. B. Raney made a lipiodol injection of the spine and a filling defect in the spinal culdesac was found.

It was felt that this lesion accounted for the visceral disturbances. On June 29, 1939, a laminectomy of the fourth and fifth lumbar vertebrae and sacrum was done by Doctor Raney, and a cystic mass, three centimeters in diameter, containing fibro-areolar tissue and atrophied nerves was removed. The sacral nerves on the right side were atrophied and were freed from the constricted portion of the dura. The lesion was considered a probable congenital anomaly.

On July 25, 1939, a lumbar sympathectomy was performed by Doctor Raney, removing the second, third, and fourth lumbar ganglia of each side and the presacral plexus of nerves. Bladder and colonic function gradually improved, and when discharged home on October 18, 1939, there was no residual

urine and the bowels moved each day by means of a rough diet and one tablespoonful of a mixture composed of equal parts of mineral oil and milk of magnesia.

A check-up x-ray of the colon by barium enema on December 9, 1939, showed an almost normal ascending, transverse and descending colon, but a long, somewhat dilated redundant loop of sigmoid. Another x-ray of the colon (nine months after lumbar sympathectomy) was done on April 8, 1940, which showed that the long redundant loop of sigmoid colon had vanished, but another smaller loop was present at the splenic flexure. The remaining colon appeared normal except for some slight dilatation of the sigmoid. The patient continues to enjoy normal colonic and bladder function, and feels very well.

Here, then, is an example of a case of obstinate constipation and urinary retention that was due to a lesion of the conus portion of the spinal cord in which there were no motor or sensory disturbances present that pointed to the existence of a cord lesion—it was only discovered by lipiodol injection. The patient was cured by excision of the lumbar sympathetic nerve fibers.

Another such case of megacolon with constipation and urinary retention which was due to a gun-shot lesion of the cauda equina was reported by Fearnsides,[14] and it necessitated opening of the abdomen to relieve intestinal obstruction.

While it is not the primary purpose of this paper to discuss the etiology and treatment of primary dysmenorrhea, I believe it is worthy of some remarks, since its cure has been obtained by lumbar sympathectomy, and because, in many of these operated cases, much improvement has also been noted in colonic function with less tendency to constipation, even though a megacolon did not exist.

Cotte,[15] first, in 1925, and later many other gynecologists, have shown that this condition is relieved by presacral neurectomy. Cotte[16] lately reported three hundred of such cases favorably operated upon, and in this country Fontaine and Herrmann,[17] Counsellor and Craig,[18] Adson and Masson,[19] DeCourcy,[20] Abbott,[13] Collins,[21] and others have reported smaller series of cases of dysmenorrhea relieved by this operation.

As an etiologic explanation of primary dysmenorrhea, it is believed that it results from either abnormal reflexes in the nerve supply to the uterus or from vasomotor spasm from some circulatory disturbance. As yet it has not been ascertained that any spinal cord lesion is responsible for the disturbance, yet it is quite possible because of the association of dysmenorrhea with megacolon and dilated bladder and because of their identical extrinsic nerve supply. Such a case was reported by Abbott[13] in which megacolon, urinary retention with dilated bladder, primary dysmenorrhea and Raynaud's disease of the feet were present. No spinal cord lesion was discovered, although no lipiodol or air injection of the spinal cord was made. Lumbar sympathectomy cured all of these four conditions.

By excising the fibers of the presacral plexus, one produces (1) vasodilatation in the uterus and broad ligament, (2) stronger detrusor or emptying of the uterus from increased parasympathetic action, and (3) interruption of afferent pain stimuli from the uterus to the lumbar spinal cord. All of these results may explain the relief from dysmenorrhea by lumbar sympathectomy.

COMMENT

It must now be recognized that the rôle of the extrinsic nerve supply to the pelvic viscera, namely, the colon, bladder, and reproductive organs, is important in explaining the presence of megacolon, atonic bladder, and dysmenorrhea. These conditions appear to be due to an overbalance of sympathetic nerve function over that of the parasympathetic supply. It is probable, with the possible exception of primary dysmenorrhea, that megacolon and atonic bladder is often due to a lesion of the cauda equina or conus. It may occur in the absence of sensory or motor changes, and only be revealed by a spinal cord injection of lipiodol, as illustrated by the case reported in this paper. When sensory and motor disturbances occur which indicate a lesion of the conus or cauda equina, then lipiodol injection is unnecessary. It should be emphasized that whenever such a lesion is discovered an attempt should be made to remove it before it causes complete destruction of the parasympathetic fibers with paralysis of the bladder and colon, when lumbar sympathectomy will do little or no good, and death will occur eventually from almost inevitable urinary tract infection.

SUMMARY

Another case of megacolon and cord bladder is reported which was due to a probable congenital lesion of the conus culdesac. This spinal cord lesion produced pressure on the parasympathetic sacral fibers, diminishing their function, thus resulting in an overbalance of lumbar sympathetic function and the production of cord bladder and megacolon. The patient was cured by lumbar sympathectomy following the removal of the spinal cord lesion, with the result that colonic and bladder function have been restored to normal, and the size of the colon to almost its former proportions.

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CHOICE IN SULFONAMIDE DRUGS*

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ALTHOUGH the sulfonamide drugs have increased pleasure in the practice of clinical medicine, they have also increased its complexity. The multiplicity of these drugs is confusing, and one is sometimes at a loss to know which drug should be used in a given case. It is the purpose of this paper to clarify the problem and outline the particular indications for the different drugs, as used at present. It must be realized, however, that, since the introduction of the sulfonamides, there have been constantly changing indications for the use of these drugs, depending on better understanding of the effects of the older ones and the availability of a steady stream of new chemically related compounds. Thus, what is said today may have to be at least partially revised tomorrow.

The mode of action of all the sulfonamide drugs appears to be similar. Likewise, when one of the drugs is superior to another in one infection, it will probably be superior in all other infections as well. This leads to the conclusion that, other things being equal, there is no indication for the use of any but the strongest drug. This conclusion is not far from the truth. The principal members may be discussed in turn.

SULFANILAMIDE

This early sulfonamide compound is the best understood drug in the group, and for this reason serves as a basis by which to judge the others. From the pharmacological standpoint it is a desirable drug, since it is easily administered, well handled by the body, and excreted without difficulty, but anemia and cyanosis are exceedingly common complications associated with its use. It is, unfortunately, less effective therapeutically than other related compounds, and is being supplanted by them in the treatment of many diseases. In those conditions in which it has not been replaced, it may be merely the absence of data on the newer compounds which have allowed its retention.

The principal indications for the use of sulfanilamide at present are in diseases where its effectiveness is quite adequate to control the situation easily. Here, because it seldom causes severe toxicity, especially urinary tract involvement, and is cheap, it may be used; but in time it will undoubtedly be given up entirely in favor of other compounds. Infections with the Hemolytic streptococcus, including meningitis, erysipelas, and sepsis, meningococcus infections, Ducrey bacillus infections, urinary tract infections due to E. coli and the need for prophylaxis before operation or tooth extraction in the presence of valvular cardiac disease, may be well met with sulfanilamide. When rectal administration is desirable, this is the only sulfonamide capable of any considerable absorption. In severe infections, an initial dose of four or five grams orally is followed by a dose of one gram every four hours, night and day, in the average adult. Each dose is halved, or the medication is given only four times a day, with clinical cure, and after four or five days at this reduced level, discontinued.

Sulfanilamide has been applied locally as a powder or paste in instances of compound fracture and peritonitis with alleged satisfactory results.

Two other compounds, prontosil and neoprontosil, should also be mentioned. These were among the first members of this group to be used clinically. Both are broken down in the body to sulfanilamide, plus an inert substance, and are only as effective as an equivalent amount of sulfanilamide. There is, therefore, no indication at present for their use. If administered in comparable dosage, toxic reactions are as frequent as with sulfanilamide.

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SULFAPYRIDINE

Pharmacologically, this is a less desirable drug than sulfanilamide, as it is poorly absorbed, highly acetylated, and excreted with difficulty, but it is far superior in therapeutic effectiveness. Infections in which sulfanilamide is quite ineffective may be controlled by its use. This outweighs its pharmacological and toxic drawbacks, even the very troublesome nausea, and it would be a highly valued drug but for the fact that sulfathiazole is equally effective and less toxic. At present the indications for its use are narrow. In serious meningitis of any type, the superior penetration of sulfapyridine into the spinal fluid, as compared with sulfathiazole, may be valuable. However, sulfathiazole penetrates through inflamed meninges better than was previously thought, and should ordinarily be adequate. Where sensitivity to sulfathiazole is present, it may be possible to give sulfapyridine without trouble, although this is by no means invariably true.

When used, it should be given in an initial dose of two grams orally, or intravenously as the sodium salt, and followed by a one-gram dose every four hours. Urinary output should be kept above 1,500 cubic centimeter daily, to diminish the possibility of the formation of urinary calculi of acetylsulfapyridine.

SULFATHIAZOLE

This is the most important sulfonamide drug in use at present. It has a wide range of potency, and is a fairly desirable drug from the pharmacological approach, although its rapid excretion may lead to the precipitation of the drug in the urinary tract. Vomiting is seldom severe, and anemia and cyanosis are much less marked than that associated with the administration of sulfanilamide.

It is applicable wherever bacterial chemotherapy is desired, and in most situations is the preferred drug. In pneumococcus and staphylococcus infections, it is definitely the drug of choice.

Sulfathiazole is more effective than the earlier sulfonamides in the treatment of urinary tract infections caused by organisms other than E. coli. Even Streptococcus fecalis has been said to be susceptible to its action, but this is, unfortunately, not the case in most instances. This drug may be used in infections associated with the colon bacillus alone, although sulfanilamide is usually entirely adequate.

The late complications—fever, skin rash, and conjunctivitis—are more frequent and severe with sulfathiazole therapy, and its use in infections requiring treatment for more than a few days is associated with greater hazards than with the sulfonamides described above.

Treatment should be started with an initial dose of one to four grams orally, or intravenously as the sodium salt if oral medication is difficult, and followed every four hours by 1 to 1.5 grams by mouth. Urinary output should be maintained above 1,500 cubic centimeters per day.

Sulfathiazole has been less used locally as a powder or paste than sulfanilamide, but there is no reason to believe it would not be as effective as that drug when this type of therapy is indicated.

SULFAGUANIDINE

This new sulfanilamide derivative is poorly absorbed, and so a considerable amount of the drug remains in solution in the bowel. It has been suggested that it may be useful in dysentery and cholera. A few clinical tests have shown, however, that larger amounts are absorbed than was previously supposed, that dysentery bacilli are not always eliminated from the stools of chronic carriers, and that its use preoperatively before operations on the bowel is not invariably attended by a significant decrease in the number of organisms present in the feces. It is decidedly in the experimental stage.

SULFADIAZINE

This well absorbed, and apparently rather nontoxic derivative, is very promising at the moment, and may prove to be the next step in the sulfonamide ladder.

PROMIN

Although quite toxic, this drug is also highly effective experimentally. Little can be said about its future.

SUMMARY

In summary, it may be said that, just as sulfanilamide gave way to sulfapyridine, which in turn gave way to sulfathiazole as a therapeutic agent in infections, so now the latter drug may be expected to yield to still more effective drugs, as these are introduced in turn. It is also probable that drugs will be developed with special indications based on specific properties. The possible value of the poorly absorbed sulfaguanidine in enteric infections is an example of this trend.

2398 Sacramento Street.

PUBLIC HEALTH ACTIVITIES AND RESPONSIBILITIES*

By Elmer Belt, M. D.
Los Angeles

THANK you, Mr. Director, for introducing me to your radio audience.

I should like to tell them that I believe the great lesson which the world tragedy of today will hold for civilization is the now demonstrated fact that those nations who have tasted freedom regard it with greater love than the love of life itself. There has been a great deal of talk about the softening effect which the democratic way of life has had upon those who dwell within a democracy. Surely, by and large, we have had greater ease and greater security and, largely due to the fact that we have all had greater leisure, those of our citizens who have a mechanical bent or scientific insight have made the way of life better for all of us by the free exercise of their peculiar geniuses. Now we have come to trial and we are sternly standing up to the standards set for us by the founders of our republic. They risked all to give us what we have and we who have taken that talent and developed it into ten talents are ready again to protect our heritage with our lives. It is not material means

* A radio address given over KFWB on June 7, 1941.

for which we fight. Suddenly, we see clearly that ideals and ethics mean more than wealth and ease and under their banners we take our stand. Yet in this hour we look back a little ruefully along the way which we have come and wish that we had done greater things with the opportunities given us. Now that we need great strength, we can see where selfish individual motives have stood in the way of greater progress.

SELECTIVE SERVICE

The operation of the Selective Service Act is revealing the fact that of 700,000 men examined, the condition of health of these men is such that only 400,000 have been found fit for military duty. These are our youths, in the age groups of greatest physical strength, yet diseases of teeth, eyes, heart, musculoskeletal structures, ear, nose and throat, hernia, venereal disease and diseases of the lungs cause three out of seven to be rejected.

DEPARTMENTS OF PUBLIC HEALTH

Our departments of public health, with the aid of our practicing physicians, have been given powers which take two forms: the protection of the public against unsanitary environmental conditions and polluted or offensive foodstuffs, and the protection of the public against the dissemination from person to person of communicable diseases. As a result of the efforts of public health departments along these two lines, diseases which could be controlled by environmental sanitation, such as cholera, plague and typhoid, have begun to disappear from civilized communities. Bacteriological and immunological methods have made rapid progress in the control of communicable diseases like diphtheria. The establishment of organized programs for hygienic living through the slow and tedious process of education has had its effect upon the national scourge, tuberculosis. Control of infant mortality has occurred due to educational propaganda which had been learned in the campaigns against tuberculosis, and along with the growth of health education has come a desire on the part of the people for health examinations at frequent intervals in order to bring about the detection of deviations from the normal in their very earliest stages. Thus the line between preventive and curative medicine has become obscure and every physician virtually becomes, in his daily practice, more and more a hygiene advisor.

The many service organizations which characterize the American way of life have also taken on their share of the promotion of public health as one of their basic public activities and then conduct campaigns for better housing, better zoning laws, systems of transportation which open up new residential districts, better roads, connecting the rural districts with the cities, improvement in agriculture and in the handling of foods.

In the last analysis, however, it is the official health agencies which must be responsible for seeing that public health is adequately protected. In the United States the fundamental unit of health organization is the local health department of the city, town or country, which consists of a board of health, a health officer and his staff. Over the local health department stands the state department of health, which also includes a state board of health or public health council, which guides the policies, and a health commissioner and staff, which executes them. The United States Public Health Service, although a part of the Federal Security Agency, exercises essentially the functions of a Federal Department of Health. It has direct control of quarantine at the seaports and of health problems of an interstate nature, and it also serves as a guiding influence for the state departments of health, just as they in turn stimulate and guide the local health departments. Thus, there is a close correlation in the United States between the federal, state and local health departments.

COÖPERATION IS IMPORTANT

But, finally, the success of the whole structure depends upon the close coöperation in the work of public health of each practitioner of medicine. Each doctor is in fact a state epidemiologist, because the law requires that he shall report cases of communicable disease to the local health officer upon a form that is provided by the state. Without these reports no activity in the control of communicable disease can be carried out efficiently. Thus each practitioner becomes an active participant in the state's organization for the maintenance of public health, and the doctor who is a good citizen is particularly careful about the discharge of this public duty.

WORK AHEAD

While much has thus been done to reduce the epidemic diseases, there remains a great deal to be done for the health of the individual. Anxiety, uncertainty and insecurity have contributed to ill health, particularly in the field of mental illness. Of one million patients in hospitals every day of the year, 600,000 are in mental and nervous disease hospitals. In this land of ours, which has the most adequate resources in the world, there are many people who come home from work exhausted, without enough food to eat, without the right kind of food to eat, greeted by children who are undernourished. Distribution of surplus commodities, general relief from federal and state aid organizations and an abundance of free medical care have helped us through lean years, but have not been enough. In the period from December, 1917, to September, 1918, when three million men were examined for military service, 70 per cent were qualified. Now only 56 per cent are qualifying. Our general population is obviously not profiting by the available advances in medical knowledge. Is it because we cannot afford medical care ?

CALIFORNIA PHYSICIANS' SERVICE

In the State of California the doctors have created an organization which they call the California Physicians' Service. It is run and owned by the doctors themselves. By means of it hospital and doctor bills may be met by those who belong to this plan on a monthly fee basis. The doctors in

the State of California are pretty largely united in an effort to make this plan a success. You will probably find that your own favorite doctor is a member of this plan, because out of 6,600 doctors in the state society, 5,500 have joined this plan.

This organization is operated upon the insurance principle and it costs those who join it very little for the immense service given, because the only overhead is a 20 per cent operating cost. This cost is diminishing in proportion as the plan grows in size.

Three different types of policies may be had. One insures against the cost of surgical procedures only and pays the cost of surgery and hospital if a surgical procedure is found to be necessary. This contract is primarily for large industrial groups. At a less cost a policy is issued which covers hospitalization only, but hospitalization for any type of illness. The third type of policy provides full coverage for medical care and hospital costs. At present 30,000 people in our State are cared for within this plan. As the public is learning of it, the curve of growth is sharply upward. Membership is limited to employed groups of persons. However, those who have salaries in excess of $3,000 annually are not permitted to join, though many such would like to do so. The Federal Government has recently shown its approval of the plan and its confidence in it by arranging to pay part of the premium for those farm families who wish to join it and who are already under the wing of the Federal Farm Security Administration. This is the contribution of the practicing physicians of the State of California to the social security of the workers of our State. It is a genuine contribution. No one is getting rich as a result of the operation of this plan. Each doctor and hospital is paid for work actually done and, except for the very small overhead for clerical work, all income is devoted to this purpose. Such fees are small but adequate and secure, and the doctors are thrilled to see that by means of this plan the most complete and modern medical service can be extended to workers everywhere throughout our State.

This is but one of the many efforts being made to protect the American way of life, while we prepare to preserve and defend it in whatever part of the world it may be challenged.

1893 Wilshire Boulevard.

RÔLE OF THE DOCTOR OF MEDICINE IN THE LIFE AND HEALTH OF THE AMERICAN CITIZEN*

By Ruth Kliewer
Bakersfield

SINCE man's emergence upon the earth, illness has been a major component of his personality. Disease has run the gamut of life with him. Medicine, trailing disease, has metamorphosed from the weird rituals of our early ancestors down the centuries to the present highly scientific application of surgery and chemotherapy in conquering the microorganisms which prey on human life. Consequently, in view of the ages which medicine has spanned, in the light of man's successes and failures in his struggle to survive, the rôle of the doctor of medicine in the life and health of the American citizen has been, is, and will continue to be one of unequalled significance.

Today, as we study the records of progress made in the various industries and professions, note the changes in social structure, and speculate on future achievements, we cannot exclude from our survey the obvious fact that the greater part of America's survival and continued development must be credited to the profession which has kept us, as individuals, alive and able-bodied: the medical doctors. More remarkable even, is the fact that they have made, during the last two and one-half decades, more contributions to the preservation of life than in all the years previous.

Let us picture, for a moment, the health situation in America at the beginning of the twentieth century. The United States was just settling back from three centuries of wars and pioneering. Conquest of unexplored territory occupied the lives of old-timers and immigrants. The great expanses which separated towns, settlements, and homesteads, plus primitive methods of travel, made communication difficult. Due to the high frequency of illness from perils of pioneering and constant exposure to reinfection from Old World immigrants, an ignorance of pestilences, the obscurity of disease, the scarcity of doctors, and the superstitions upon which aid was administered, the system of living was precarious. Sanitation was a term foreign to the populace. Approaching symptoms of disease eluded recognition. Subjecting herself and her child to the hazards of unhygienic surroundings and inadequate accommodations, the prospective mother was confined in her own home and was delivered by a midwife. New-born generations were fed on adult foods from the very start, and a harvest of 1,500,000 American citizens was reaped by Death in 1900, nearly one-third of which died of diseases seldom occurring today, so well are their causes and treatment known.

Thus we, as part of a human race afflicted since its origin by a myriad of diseases, and made stupid and incompetent thereby, and devoid of scientific treatment for our afflictions, presented to the medical doctor less than half a century ago a problem of stupendous propensity.

With the birth of cities, the West conquered, state governments established, the nation unified, the institution of more efficient communication, the successful establishment of public education, the extension of mechanical inventions, and the complex social situations created by the spirit of the new era and the increasing population, came an opportunity for more Americans to devote their energies to physiological, chemical, and bacterial research. Then, from the few general laws of science known and accepted, and a less number of

* Prize essay in contest open to high school and junior college students, sponsored by the Committee on Public Health Education of the California Medical Association, May, 1941.
Essay prize was awarded to Miss Ruth Kliewer, a student in the Bakersfield Junior College, Bakersfield, California.

significant discoveries to draw from, medicine, as we know it today, began to change like a kaleidoscope, and the physician assumed a new rôle in American life: a responsibility for the health of his countrymen as a unit—a duty of finding disease, treating it, and eliminating it from among the perils we combat. The vision and toil of a few exceptionally outstanding medical men, and those who followed them through the pioneering phases of modern medicine, sincerely devoted to the finest that the term "Medical Profession" implies, must be credited for a generous portion of what progress has been made, what increased health fortifications we now have: For the decrease of infant mortality, and a corresponding extension of the average life.

Therefore, the rôle of the doctor of medicine in the life and health of our American citizenry must be presented in two parts: The significance of his services since 1900, and his future contributions to national health.

I

Today the annual number of deaths is approximately what it was forty years ago, but the population is 56,000,000 greater than in 1900. This means that the death rate has dropped 60 per cent in less than half a century; an excellent indication of victory over our microscopic enemies. It also means that today there are 72 more persons in every 1,000 of our population who are escaping death from disease, illness, or accident than there were four decades ago, or that in a city of 100,000 population, you have 715 more chances to live this year than you would have had in 1900. From this it is evident that the illnesses leading to death have been greatly controlled by scientifically applied medicine. Typhoid epidemics which occurred yearly, are today not listed by the census bureau as a major cause of death. In 1900, typhoid caused 36 deaths per 100,000 population; today it is responsible for less than 2. Diphtheria, which then claimed in death 43 of every 100,000 citizens, today claims only 2. Four decades ago pneumonia killed one in every 500 persons. Today it takes one in 1,500. Cholera, typhus, smallpox, yellow fever, and malaria have also fallen before the relentless onslaughts of our nation's medical men. Tuberculosis is now only one-fourth the White Plague that it was forty years ago! In four years, our doctors have so changed our attitude towards social diseases, and have persisted so intensely in the fight for control and potential elimination of syphilis and gonorrhea from our bodies, that together with the recent new, quick, and effective methods of treatment, and with premarital examinations required in at least eighteen states, we stand an encouraging chance of freeing ourselves from a disease which has ravaged man's body and degenerated his brain since before the Christian era. Infant deaths due to congenital malformations and diseases have been reduced by one-half, and the majority of today's prospective mothers are cared for in hospitals or maternity homes. Diets for babies and children are now given special attention, and child supervision by a physician is gaining in popularity among the younger parents who realize that parenthood does not endow them with the training, knowledge, experience, and resources of the doctor. These accomplishments have been due in part to research, of course, but due to the conclusions of such research as have been dispensed to the public by the medical practitioner.

With increased successes and the voluntary incorporation of extended responsibilities, the private practice of medicine has shifted its emphasis from illness to health and correct hygienic supervision of the healthy. Various methods have been employed in this process. Public interest and support of health programs have been acquired by a more appealing dissemination of information, through more, far-reaching channels of propaganda. Doctors of the American Medical Association pioneered this educational aspect through the establishment of a bureau of health and public instruction and publication of the magazine, *Hygeia*. Our physicians have organized and published information in bulletins, books, pamphlets, and speakers' bureaus, and have sponsored radio programs. Realizing that man cannot be forced against his will to accept what is best for him, the medical profession has been so successful in making us desirous of their services that the dangerous situation has now arisen in regard to how their services can be made available to all of our populace who demand them! So now our doctors have the medical-economic responsibility of providing a system whereby every American citizen can receive adequate medical care regardless of his financial status.

Already many experiments are under way, one of the most prominent of which is the California Physicians' Service under the chairmanship of Dr. Ray Lyman Wilbur. Indicative of the attitude of the medical profession toward these changes in methods of practice, is a statement made by Doctor Wilbur, who said, in regard to members of group service: "Our sympathy, our sense of 'fair play,' and our desire for self-protection and self-projection all unite in demanding that we reject emphatically any suggestion that these people should be given an inferior service—a service that we cannot label 'good in quality and reasonably adequate in quantity.'"

The evolution of any system, if inclusive and successful enough to make adequate medical services available to all our people, will perhaps, in itself, be regarded as the greatest contribution that has yet been made to our lives and health, when our civilization is viewed by historians of the future.

Also as a principal step in the maintenance of public health and continued conquest of disease, and essential to early discovery of any disease processes, our doctors instituted a plan of periodic physical examination, and are striving to develop a public view that one person's health or illness is everybody's business. Therefore, in comparing attitudes of today with those of the past few decades, we find a shift from that of extreme indifference, ignorance, and superstition in matters regarding disease, to one of great enlightenment and constantly expanding health consciousness on the part of the American public. This is a remote

indication that the relief dispenser may also play a significant part in helping us as a nation to catch up with the lag we have allowed to occur in self-control, until it equals scientifically the degree of control we have attained over our environment.

The work of our National Health Department, administered by medical doctors and directed by a Surgeon General, cannot be ignored. This particular medical group has perhaps been more responsible for the success of other practitioners than we realize, for to them full credit must be given for guarding us from exposure to diseases carried to our shores by international travelers, and by those immigrants seeking residence here. These public doctors have the task of:

1. Medically inspecting and examining all arriving aliens.
2. Preventing interstate spread of disease.
3. Suppressing epidemics.
4. Investigating causes and methods of preventing disease.
5. Supervising and controlling the manufacture and sale of all biologic products used in prevention and treatment of disease.
6. Maintaining facilities for confinement and care of drug addicts.
7. Collecting, compiling, and publishing information regarding the prevalence of disease in the United States and in foreign countries.

During the past year, by examination of applicants for immigration visas, our medical officers protected us from contact with 13,500 afflicted with a condition or disease likely to affect their ability to earn a living. Another 22,000 alien passengers and 1,000 seamen were found to be afflicted with some mental or physical defects of disease.

And finally, in philanthropic, nonmedical organizations devoted to promoting health, expenditures are seldom made without the advice and recommendations of a general advisory committee consisting of competent, qualified doctors.

Thus our medical doctors have lobbied for public health, and thus have they rapidly renovated our attitudes concerning self-preservation and physical well-being.

II

Vast territory has been covered in the four decades just passed, but so boundless is the frontier that the challenge of the future presents incalculable possibilities.

Illness has been drastically reduced, but there are still 6,000,000 men, women, and children unable to work, attend school, or pursue other ordinary activities on any one average winter day, on account of illness, of a gross physical impairment resulting from disease, or accidents. A score of dreadful diseases are now well conquered, but nearly one-half of the 6,000,000 are suffering from chronic diseases; about 1,500,000 from colds, influenza, and pneumonia; 2,500 from acute infectious diseases, and appendicitis. For every death reported, there occur sixteen cases of illness disabling for a week or longer. On a per capita basis, every man, woman and child in the nation's population suffers at least ten days of incapacity annually from illness.† More than a million of us are made inefficient by hookworm and other parasites, while 10,000,000 are victims of syphilis, and 60,000 of our newly born, future citizens are infected with it. What a laboratory for those whose occupation is to discover disease, treat it, and cure it, if possible!

In addition to this, 1,500,000 persons in the United States are mentally defective. From 1,500,000 to 2,000,000 others are diseased. Six out of ten hospital beds are occupied by mental patients, besides those cared for in outside institutions.‡ With the possible effects of disease upon the nerves and brain cells becoming more and more apparently a contributory factor to many forms of insanity, mental health also is now shifting from the field of pure philosophy and psychology into the realms of medicine and the hands of the medical doctor.

Thus, it is obvious that beyond the realm of superficial progress in American economic and cultural phases, true progress must be credited to the part that the doctor of medicine has played and will continue to play in the life and health of American citizens. The future holds for him adventure, exploration, discovery in increasing magnitude. His rôle is one that will not be finished until the last citizen is free of disease, and the sources of infection are eliminated. His rôle in the future will be greatly influenced by the extent to which we project all that has been accumulated, through medical research and application, into terms of human value and happiness for that part of life that we and coming generations yet shall live. If we accept that responsibility, our doctors' efforts and sacrifices may be turned toward other achievements now not dreamed of.

We are paying a terrible price in terms of life and happiness for those maintained in institutions. Our institutions need a medical aspect. Jails, orphanages, old peoples' homes, soldiers' homes, insane asylums, all afford well-supplied laboratories for research in pathology, bacteriology, therapeutics, and biogenetics. It may even come about that in the future, if the doctor is not hampered, he, instead of emotionally unjust juries, will pass the sentence upon our criminals.

The doctor of medicine assists us into life, protects us from ourselves while we live, extends our span of life, and administers relief at death.

And so, as the evolution of man continues, if the United States survives the conflicts of nations to rise above the petty dabble of narrow minds, and reaches, in the centuries ahead, these social ideals (and even if not), the profession of medicine, those who lead it, and those who follow it, will have made the most constructive and enduring contributions to the lives and health of America's citizens that this era has received.

In conclusion then, as I study our social problems and those things which cause them, I am convinced that this campaign for health in the United

† National Institute of Health and Public Health Service, 1938.

‡ *Science Monthly*, 47:550-551.

States, this effort on the part of doctors to show us a way to a biologic understanding of ourselves, is more important to us now and in the future than any other national or international situation, because physical health and mental well-being are indispensable if our civilization continues to progress. Then, if a certain degree of national mental well-being can be attained in future years, together with a more relaxed pace of living, a more peaceful community life will necessarily evolve. And it is even feasible that only through universal physical and mental health can the prophet's dream of a war-free world materialize.

The American doctor of medicine, then, dedicating his mind and strength to the prevention of premature organic deterioration in his fellow citizens, and to intercepting processes of deterioration in those victimized by disease, with ever increasing emphasis upon both, particularly the first, shall continue to be, but in a greater capacity, the Moses who leads his followers from the wilderness of physical devastation to a land more promising of organic protection, physical health, and mental superiority through knowledge and hygienic living.

315 Holtby Road.

REFERENCES

Statistics: World Almanac, 1940; American Year Book, 1940; Reports of the Committee on the Costs of Medical Care.

Magazines: Hygeia, 1940; American Journal of Public Health; Scientific American, 1940; Science News Letters; Science Monthly.

Books: "The Fight for Life," De Kruif; "20th Century Psychiatry," William White; "Our Children in a Changing World," Erwin Wexberg; "A Short Introduction to the History of Human Stupidity," W. B. Pitkin; "The March of Medicine," Dr. Ray Lyman Wilbur; "Your Diet and Your Health," Fishbein; "The Patient's Dilemma," Cabot.

CLINICAL NOTES AND CASE REPORTS

OAK POISONING: CAUSE-REMOVING TREATMENT

By Edwin F. Patton, M. D.
Los Angeles

MOST prevailing treatments of oak and ivy poisoning are directed toward (1) relieving the discomfort till the disease runs its course, and (2) developing neutralizing substances in the blood of the victim.

Another, and preferable approach, (3) removing the cause, is here described because it is so simple and so effectual in cutting short the affliction.

The cause, an oleoresinous plant exudate, acts as an irritant as long as it is in contact with the skin, even in exceedingly minute quantity. This substance is not soluble in water; hardly at all in alcohol; is partially emulsifiable in soapsuds; is freely soluble in certain cleaning agents, notably benzine.

By mopping up small areas in series with individual benzine-soaked pledgets of cotton or small rags, discarding each pledget or rag after use, and continuing until all affected surface has been so treated, a good deal of the offending irritant can be picked up and removed. A little gentle scrubbing makes the removal more complete. Of course, any previously applied coating of calamine, or other medicament, which merely covers the oleoresin and binds it into intimate contact with the skin, must be removed to get at the underlying toxin. On fairly fresh lesions this treatment is not particularly painful. After the skin is broken, the treatment becomes increasingly heroic—yet justifiable because of results.

After a session with benzine the part treated should be left exposed and fanned till the benzine is completely evaporated. Then a thorough lathering and hot showerbath (not *tub* bath) may follow. Then, if itching continues, full strength Dobell's solution may be daubed on *ad libitum* and allowed to dry, or may be used as a wet compress.

The whole process may have to be repeated a second or perhaps a third time, at intervals of a few hours, before enough of the oleoresin has been removed to allow healing; but when this is accomplished, regardless of the previous duration of the disease, twelve to thirty-six hours will see the healing stage well under way.

Sedatives, however, may have to be used during the treatment period.

3875 Wilshire Boulevard.

HIPPOCRATES' APHORISMS*

By Moses Scholtz, M. D.
Arcadia

Section Five (Continued)

47. A prolapsed womb
With suppuration,
Leads to sinus
And ulceration.

48. A male fetus is located
Most often to the right,
While the female is found rather
Moored to the left side.

49. A free expulsion of the placenta
Can be produced with greater ease,
If, with the mouth and nostrils shut,
The woman can be caused to sneeze.

50. To stop the menses in a woman
One should apply cups to the breasts.
The largest cups 're the most effective—
So the experience attests.

51. In a state of pregnancy
The mouth of the womb is closed.

52. If in a pregnant woman flabby breasts
With milk secretion overflow,
The fetus's weak, but firm breasts
Suggests a healthy embryo.

* For other aphorisms, see California and Western Medicine, March 1940, page 125; April 1940, page 179; May 1940, page 231; July 1940, page 35; August 1940, page 85; September 1940, page 130; December 1940, page 272; January 1941, page 27; February 1941, page 82; March 1941, page 124; April 1941, page 229.

53. Shrinking breasts suggests miscarriage,
But, if they do regain their size,
With pain in breasts, hips, eyes or knees
The mishap will not materialize.

54. If the mouth of the womb is hard,
It is also shut and barred.

55. Emaciated women who are pregnant
And seized with fevers with no apparent cause,
Are due for arduous labor, and miscarriage
May bring them dangerous and even fatal woes.

56. If fits and fainting supervene
On excessive menstruation,
It is an evil combination
Which bodes a hard and painful course.

57. Both, when menses are excessive
And when they're scant or fully checked,
Morbid changes in the womb
Female maladies attract.

58. Inflammation of bowel and womb,
Or kidney suppuration,
Cause strangury, and hiccup comes
Following liver inflammation.

59. To test a woman for power to conceive,
Wrap her in blankets and fumigate below;
Should the scent pass through the body to the mouth,
Her womb is good soil for seed to set and grow.

60. If a woman with child
Continues with her menses,
The fetus is bound to show
Injurious consequences.

61. If a woman's menses are suppressed,
And neither chills nor fever do appear,
And, if by nausea she's harassed,
That she's pregnant, becomes clear.

62. Females whose wombs are cold and dense
Or humid do not well beget;
For semen can't survive in there,
By an adverse medium beset.
And, if the womb is hot or dry,
The semen dies for wont of food;
The state of womb between these two
Would seem for seed the best to do.

63. Likewise in males, because of weakness,
Semen is not propelled within;
If it's too dense or hot or cold,
It does not reach the proper channels
And, unproductive, stays between.

64. Milk is bad for headaches, colics,
Thirst, bilious fevers and those who've bled;
But milk is good in chronic fevers,
For chronic phthisics and the underfed.

65. Swelling on wounds prevents fits and delirium,
Convulsions and tetanus come when it wanes
From wounds in the rear, while front wounds more often
Cause madness, dysentery, pus and chest pains.

66. If severe and evil wounds
Do not bulge and do not swell,
It can have but a single meaning:
They are dangerous and fell.

67. Soft tumors
Are benign;
Hard ones
Are malign.

68. When one has pains
In the back of his head,
He can be relieved,
If his forehead is bled.

69. In women chills start from the loins
And move up to the back of the head;
In men—from the dorsum of arms and thighs,
Where the skin's cold and bare, they spread.

70. In those who suffer with quartan fevers,
Convulsions are not often seen,
And those, attacked with such convulsions,
Get well, if quartans supervene.

71. Those whose skin is hard and parched
End an illness without sweat;
But, when the skin is loose and thin,
The end of illness leaves the skin wet.

72. The sick with a jaundice incidence
Are not inclined to flatulence.

Section Six

1. If in chronic lientery
Acid belching does occur,
It can be properly regarded
An auspicious harbinger.

2. The persons who have humid noses,
And those whose seed is thin as dew,
Oft have impairments of the body;
The contrary is also true.

3. In chronic cases of dysentery
Distaste for food is a sign adverse
And, when accompanied by fever,
It makes prognosis that much worse.

4. Ulcers combined
With a loss of hair
Denote noxious
Disrepair.

5. It is of serious import
To know the nature of various pains
In the breasts, the sides and other parts,
And to what their difference pertains.

6. Old men's kidneys and the bladder,
When stricken by disease,
Are refractory to cures
And to remedies.

7. The nearer to the surface
Stomach-pains are set,
The milder is their nature;
The deeper, the more severe they get.

413 Longden Avenue.

(To be continued)

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

HENRY S. ROGERS, M.D.....President
WILLIAM R. MOLONY, SR., M.D.....President-Elect
LOWELL S. GOIN, M.D.....Speaker
PHILIP K. GILMAN, M.D.....Council Chairman
GEORGE H. KRESS, M.D.....Sec'y-Treas. and Editor
JOHN HUNTON.....Executive Secretary

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COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

I.—First Meeting at Del Monte

Minutes of the Two Hundredth and Ninety-First (291st) Meeting of the Council of the California Medical Association

Meeting was held in the Hotel Del Monte at Del Monte, Sunday, May 4, 1941, at 8 p. m.

1. Roll Call.

Present: Councilors Philip K. Gilman (Chairman), Harry H. Wilson, Henry S. Rogers, Charles A. Dukes, Lowell S. Goin, E. Earl Moody, Elbridge J. Best, Sam J. McClendon, Edward B. Dewey, Dewey R. Powell, Calvert L. Emmons, Louis A. Packard, Axcel E. Anderson, R. Stanley Kneeshaw, Oliver D. Hamlin, Frank A. MacDonald, John W. Green; Donald Cass, Public Relations Chairman; George H. Kress, Secretary-Editor.

Absent: Councilors John W. Cline (out of state) and George D. Maner.

Present by invitation: E. Vincent Askey, Vice Speaker; Frank R. Makinson, Chairman of Committee on Public Health and Education; Dwight H. Murray, Chairman of Committee on Public Policy and Legislation: Dr. Ray Lyman Wilbur, Chairman of Board of Trustees, California Physicians' Service.

Present by request: John Hunton, Executive Secretary; Hartley F. Peart, Legal Counsel; and Howard Hassard, Associate.

2. Minutes.

Minutes of the 290th meeting of the Council held on February 23, 1941, were approved. (Abstract was printed in California and Western Medicine, April, 1941, on page 230.)

3. Membership.

(a) *Report on Current Membership.*—Report as of April 30 showed that 6,246 members have paid the 1941 dues (inclusive of 238 new members). A total of 619 members, who paid their dues in 1940, had not yet remitted for the year 1941.

(b) *Retired Memberships.*—The respective component county societies, having presented applications in regular form, it was voted that retired membership in the California Medical Association be granted to the following members:

Richard W. Baker, Los Angeles County.
Willoughby G. Dye, Los Angeles County.
William C. Finch, Los Angeles County
Peter M. Suski, Los Angeles County.
Minnie A. Seavey, Sacramento County.
William A. George, San Bernardino County.
Ross C. Martin, San Bernardino County.
Edgar James Farrow, San Diego County
Trueman A. Parker, San Diego County.
Emma K. Willits, San Francisco County.
Michael W. Kapp, Santa Clara County.
Frank A. Yoakman, Ventura County.

4. California Physicians' Service.

Dr. Ray Lyman Wilbur, Chairman of the Board of Trustees of California Physicians' Service, was present by invitation and outlined briefly the objectives of California Physicians' Service, and the procedure that had been inaugurated to develop it into a medical service organization that would be sound financially, and at the same time be able to make available to beneficiary members the best quality of medical service. Because of conditions existing at the time California Physicians' Service was instituted, it was deemed advisable to place a ceiling of $3,000 as the net income of workers who would be eligible to beneficiary membership. The number of members having ceiling incomes was small, and consisted mostly of foremen or executives whose good will and prestige made possible the securing of groups of other workers in some of the industrial plants. Attention was also called to the fact that, under present emergency conditions, it appeared that a considerable number of workers who previously had received net incomes of less than $3,000 would be placed in the ceiling class; and that to take action depriving them automatically of beneficiary membership might create unrest and result in loss of groups having considerable membership. Doctor Wilbur stated it seemed advisable, therefore, to take no drastic action at the present time.

A general discussion followed, with reference to presentation of a resolution on behalf of the Council, in which the reasons for maintaining the existing set-up would be given. It was felt that when members of the California Medical Association who were professional members of California Physicians' Service appreciated the past, existing, and future problems of the organization, there would be comparatively little opposition to maintaining the present status of eligibility requirements for beneficiary member-

† For complete roster of officers, see advertising pages 2, 4, and 6.

ship. Discussion was participated in by Doctors Powell, Dewey, Packard, Wilson, Kneeshaw, Goin, and Best.

Upon motion duly made and seconded, the Chairman of the Council was instructed to appoint a committee to draft a resolution that would be in line with the discussion. Committee appointed consisted of Councilors Powell, Emmons, and Kneeshaw.

5. **Committee on Public Health Education.**

(*a*) Dr. Frank R. Makinson, Chairman of Committee on Public Health Education, presented a report concerning the work of that committee and stated that Miss Ruth Kliewer, a student in the Bakersfield Junior College, had been awarded first place in the high school- junior college essay contest for her paper on "Rôle of the Doctor of Medicine in the Life and Health of the American People." Doctor Makinson added that it was the intention to print the essay and give it wide distribution.

(*b*) Balance to the credit of the Committee on Public Health Education was stated to be $14,390.38.

(*c*) Chairman Makinson also reported concerning the matter of engaging the services of a publicist at possible expense of $4,000 to $5,000 a year. The Los Angeles man who had been contacted had agreed to furnish an essay once a week, for which the sum of $50 would be paid. The California Medical Association headquarters would bear the expense of distribution to newspapers. Statement was made that the Committee on Public Health Education was not unanimous in recommending the plan, and that it was desirable that the Council should decide the matter.

After discussion, participated in by Doctors Wilson, Rogers, Packard, Askey, and Powell, upon motion duly made and seconded, it was voted that the Council go on record as not being in favor of the plan, in the belief that the funds could be expended to better advantage along other lines of public health education.

(*d*) Basic Science Initiative. Legal Counsel Hartley F. Peart reported that the Basic Science Act had been presented to the Attorney-General of the State of California, who has prepared a title and summary of the chief purposes and points of the proposed measure as follows:

Basic Science Act.—Initiative. Creates Board of Examiners in basic sciences (naming five sciences) comprising five members with prescribed qualifications appointed by Governor. Requires persons obtain basic science certificate from said Board after written examination before applying to Medical, Dental, Osteopathic or Chiropractic Boards, or other governmental authority, for license to practice healing art (defining same) or any phase thereof. Exempts various professions, present licensees and persons treating sick by prayer in practice of any well-recognized religion. Prescribes examination fees, penalties for violations and disposition of fines, requiring proceeds therefrom used for administering Act. Declares existing statutes not repealed.

As proponents of the Act were the following:

Representing the California Medical Association: Harry H. Wilson, M. D., 1919 Wilshire Boulevard, Los Angeles; Henry S. Rogers, M. D., Petaluma; Phillip K. Gilman, M. D., 2000 Van Ness Avenue, San Francisco; Donald Cass, M. D., 5300 Hollywood Boulevard, Los Angeles; and representing the California State Dental Association and the Southern California State Dental Association, Ernest Sloman, D. D. S., 344 Fourteenth Street, San Francisco.

The suggestion was made that the Committee on Public Health Education and the Committee on Public Relations coöperate in the work of securing signatures and carrying the campaign of education concerning the Basic Science law.

6. **Kern County Hospital Publicity.**

Doctor Packard spoke of an article that was under consideration by the *Reader's Digest,* that periodical having sent its representative to interview the Kern County Hospital authorities and the Kern County Medical Society relative to the backgrounds involved in Kern County Hospital activities. Doctor Packard stated that subsequently he had received word from the publication's New York office that they had changed their plans.

7. **Medical Services by Hospitalization Groups.**

Doctor Wilson outlined the history of the three hospital and indemnity service groups now operating in California, and spoke of their relation to California Physicians' Service. He referred also to the action taken by the Council at its meeting in Los Angeles on October 6, 1940, at which time it was proposed that approval would be withdrawn if certain conditions were not rectified. Discussion was participated in by Doctors Goin, Garland, and Moody. Motion was made that the matter be laid on the table for further discussion at the Council's meeting to be held on Tuesday.

8. **California and Western Medicine.**

(a) *Editorial Board.*—Chairman Gilman referred to the action taken by the Council in its meeting on February 23, 1941, at which time he was instructed to prepare a list of nominations that would be in accordance with the resolution for the creation of an editorial board that had been adopted by the Council. After informal discussion, a special committee, consisting of Doctors Moody, Best, and Packard, was instructed to study the list of nominations and to submit the same at the next meeting of the Council, with such changes as might be deemed desirable.

(b) *Proposal to Have a Contractor Print the Official Journal.*—Discussion was had concerning the relative costs involved in printing the Official Journal. Executive Secretary Hunton presented a breakdown of the actual cost of California and Western Medicine in 1940, and in parallel columns indicated what would be the costs under the contract proposed by Mr. Gardiner. Also, what would be the expense under the revised set-up of California and Western Medicine if handled through the California Medical Association office, directly under the supervision of the Business Manager. It was shown that the net loss of California and Western Medicine in 1940 (that is, when based upon advertising income alone without reference to a subscription allocation of members as demanded by the United States Postal Department) was $8,142, and that under the Gardiner proposal the loss would be $7,148, whereas under the California Medical Association Business Manager plan the loss would be only $4,561. Per member, the loss under the three plans was estimated at $1.19 (larger issues of 1940), $1.05 (Mr. Gardiner's proposal), and $0.686 (California Medical Association, with proposed changes). A general discussion followed, in which emphasis was placed upon the desirability of having the constituted officers of the California Medical Association remain in control of advertising, etc. Upon motion by Doctor Best, seconded by Doctor Powell, it was voted to continue to carry on the Official Journal under the system that had obtained from the time it was established in 1901.

It was agreed that the Business Manager should obtain additional bids, not only in San Francisco, but in Los Angeles, and that proposed printing economies should be instituted.

9. **Medical Preparedness.**

Doctor Gilman, Chairman of the California Committee on Medical Preparedness, gave a progress report. Doctor Green presented a possible resolution dealing with men called into service, but it was agreed it would not be wise to introduce it as part of the Council report.

10. Legislation.

Dr. Dwight H. Murray, Chairman of Committee on Public Policy and Legislation, gave a report on the work that had been done by that committee during the present session of the Legislature, and outlined the status of measures having relation to medical practice and public health.

It was emphasized that members and component county societies should not give independent approval to proposed legislation. It was felt that all endorsements should go through the headquarters office or through the Committee on Public Policy and Legislation.

11. Sectarian Medicine Proposal.

Chairman Gilman stated that there had been no new developments subsequent to the letters that were forwarded to the Council on Medical Education of the American Medical Association, the Association of American Medical Colleges, and the National Specialty Board.

12. Legal Department.

Legal Counsel Peart reported on the reversal opinion that had been handed down by the Fourth District Court of Appeal, which would grant a new trial to a former member, who had been deprived of membership by the Kern County Medical Society.

Mr. Peart stated that a petition for a rehearing would be filed and that, if this was denied, appeal would then be taken to the Supreme Court.

13. California Industrial Welfare Commission.

Executive Secretary Hunton reported upon a plan proposed by the California Industrial Welfare Commission, that a wage board be appointed having representatives of employers, employees, and the Commission. The State Commission desired to make a survey of wages received by minors and females, with particular reference to employees who are engaged in professional and other groups.

Upon motion duly made and seconded, it was voted to authorize the Council Chairman to appoint a representative for the California Medical Association.

PHILIP K. GILMAN, *Chairman.*
GEORGE H. KRESS, *Secretary.*

* * *

II.—Second Meeting at Del Monte

Minutes of the Two Hundred and Ninety-Second (292nd) Meeting of the Council of the California Medical Association

The meeting was held in the Hotel Del Monte at Del Monte, Monday, May 5, 1941, at 4 p. m.

1. Roll Call.

Present: Councilors Philip K. Gilman (Chairman), Harry H. Wilson, Henry S. Rogers, Charles A. Dukes, Lowell S. Goin, E. Earl Moody, Elbridge J. Best, Sam J. McClendon, Edward B. Dewey, Dewey R. Powell, Calvert L. Emmons, Louis A. Packard, Axcel E. Anderson, R. Stanley Kneeshaw, Oliver D. Hamlin, Frank A. MacDonald, John W. Green, George D. Maner; Donald Cass and George H. Kress.

Absent: Councilor John W. Cline (out of state).

Present by invitation: L. Henry Garland, Secretary of the San Francisco County Society.

Present by request: Messrs. John Hunton, Hartley F. Peart, and Howard Hassard.

2. California Medical Association Special Assessments of June, 1939.

The report of the Special Committee, consisting of Councilor Maner and Legal Counsel Peart, concerning recommendations on proposed procedures in relation to physicians who were members of the California Medical Association in 1939, and who did not pay the special assessment of June 1, 1939, was submitted to the Council. After discussion, it was voted that the report, as modified, should be attached to the Council's report as an addendum, to be submitted with other addenda at the meeting of the House of Delegates on Monday, May 5.*

3. Report of Special Committee to Submit Nominations for the Standing Committees.

A special committee, consisting of Councilors Green, Dewey, and Best, was appointed to bring in suggestions to the Council on how vacancies on the standing and special committees should be filled, this committee to make report at the Council meeting to be held on Wednesday, May 7.

4. Report Concerning California Physicians' Service.

A special committee, consisting of Councilors Powell, Emmons, and Kneeshaw, submitted a report concerning problems having to do with administration of California Physicians' Service. After discussion and modification, it was voted that the report, as amended, should be attached to the Council's report as one of the addenda, to be presented on May 5 to the House of Delegates by Council chairman.

5. Medical Services by Hospitalization Organizations in California.

Dr. L. Henry Garland, a member of the Pacific Roentgen Club, outlined to the Council the actions taken by the House of Delegates of the American Medical Association, the California Medical Association, and the California Medical Association Council in relation to medical services such as clinical laboratory, x-ray and anesthesia work, when such medical services were a part of the benefits provided through nonprofit or other hospitalization groups.

Mention was made of recent conferences with the representatives of the Associated Hospital Service of Southern California.

General discussion followed, participated in by Councilors Goin, Rogers, Cass, McDonald, Moody, Packard, Wilson, Dewey, and Emmons.

The delicacies of certain legislative and other existing conditions and the desirability of having a unified and harmonious plan in operation by the three hospital associations of California (Hospital Service of California, Oakland; Associated Hospital Service of Southern California, Los Angeles; and Intercoast Hospitalization Insurance Association, Sacramento) were pointed out.

President Wilson felt that the work that would be involved in solving some of the problems would take much time and that it was desirable that the responsibility should not be shuttled to the shoulders of individual councilors, but rather to the headquarters office personnel, acting with and under the direction of the Council chairman.

Upon motion by Doctor Wilson, seconded by Doctor Dukes, the following resolution was presented:

Resolved, By the Council of the California Medical Association, that the indemnification and/or agreement to make available the professional services of any kind or character by hospital associations is inimical to public welfare and is contrary to professional ethics; and be it further

Resolved, That approval by the California Medical Association and professional support is conditioned upon strict compliance and adherence to this principle.

Discussion then followed concerning the resolution. On motion by Councilor Goin, seconded by Councilor Dewey, it was voted to postpone action on the resolution until the next meeting of the Council.

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* Addenda to Council Report appear in the minutes of the meeting of the House of Delegates, of May 5, 1941.

6. **Nominations for the Editorial Board.**

The special subcommittee, consisting of Councilors Moody, Best, and Packard, and which had been appointed to consider the names submitted by Council Chairman Gilman for placement upon the Editorial Board, through Councilor Moody, Chairman, brought in a progress report, recommending that Dr. George Barnett of San Francisco act as chairman of the entire group. Upon motion by Rogers, seconded by McClendon, the revised list was tentatively approved as read. The initiation of the work of the Editorial Board would be left to Council Chairman Gilman, who, by the terms of the Council resolution would also appoint the Executive Committee of the Editorial Board.

7. **Resolution No. 2 of the Coronado Annual Session.**

Councilor MacDonald, chairman of a special subcommittee, presented the report concerning Resolution No. 2, which was printed on pages 265 and 283 in the June, 1940, issue of California and Western Medicine.

It was voted that the subcommittee's report be attached to the Council's report as an addendum, and that Council Chairman Gilman present the same to the House of Delegates.

8. **Amendment Regarding Dues of New Members Admitted During the Last Six Months of a Calendar Year.**

A proposed amendment relating to dues of new members admitted during the last six months of a calendar year, as drafted by the legal counsel, under instructions from the Council, was read, and on motion duly made and seconded, it was voted that the same be presented to the House of Delegates on behalf of the Council.

9. **Proposed Amendment Concerning Exemption of Dues of Members Who Are Inducted Into the Military Service.**

A proposed constitutional amendment that would provide ways and means whereby State Association dues of members who have been or may be inducted into the military services could be waived was read and, on motion duly made and seconded, it was voted that Council Chairman Gilman present the same to the House of Delegates on behalf of the Council.

10. **National Physicians' Committee for the Extension of Medical Services.**

President Wilson spoke concerning the presentation by Mr. John M. Pratt at the general meeting on Monday, May 5, in which some of the work of the National Physicians' Committee had been briefly indicated. Doctor Wilson stated that he felt the activities of the National Physicians' Committee were worthy of wide support and that component county societies should be urged to coöperate with the organization.

11. **Adjournment.**

On motion duly made and seconded, adjournment was taken, to meet again on Wednesday, May 7, at 4 p. m.

Philip K. Gilman, *Chairman.*
George H. Kress, *Secretary.*

* * *

A meeting was called, to be held in the Hotel Del Monte, Del Monte, on Tuesday, May 6, at 4 p. m.

A quorum not being present, no formal meeting was held. The members present informally received invitations for the 1942 annual session from the Hotel Coronado of San Diego County, Hotel Huntington of Pasadena, and Hotel Del Monte of Del Monte.

Philip K. Gilman, *Chairman.*
George H. Kress, *Secretary.*

III.—Third Meeting at Del Monte

Minutes of the Two Hundred and Ninety-Third (293rd) Meeting of the Council of the California Medical Association

Meeting was held in the Hotel Del Monte, Del Monte, on Wednesday, May 7, 1941, at 4 p. m.

1. **Roll Call.**

Present: Councilors Philip K. Gilman (Chairman), Harry H. Wilson, Henry S. Rogers, Charles A. Dukes, Lowell S. Goin, E. Earl Moody, Elbridge J. Best, Sam J. McClendon, Edward B. Dewey, Dewey R. Powell, Calvert L. Emmons, Louis A. Packard, Axcel E. Anderson, R. Stanley Kneeshaw, Oliver D. Hamlin, Frank A. MacDonald, John W. Green, George D. Maner; Donald Cass and George H. Kress.

Absent: Councilor John W. Cline (out of state).

Present by request: Messrs. John Hunton, Hartley F. Peart, and Howard Hassard.

2. **Place of Meeting for the 1942 Annual Session.**

(*a*) Consideration was given to the invitations received from Hotel Coronado of Coronado, in San Diego County, Hotel Huntington of Pasadena, and Hotel Del Monte of Del Monte. After discussion of the relative merits and advantages of the three places, upon motion by Councilor Maner, seconded by Councilor MacDonald, it was voted that Hotel Del Monte was the Council's choice for the place of meeting for the 1942 annual session, and that the House of Delegates be so informed.

(*b*) Upon motion by Councilor Packard, duly seconded, it was voted that a special committee, consisting of the Council Chairman, the Association Secretary, and Executive Secretary, be appointed to confer with officials of the Del Monte Properties Company relative to possible improvements that would make for additional conveniences, making it possible for the California Medical meeting to meet at Del Monte from year to year. It was felt that with better facilities, such a plan might be possible.

3. **Nominations for Editorial Board.**

The special subcommittee, consisting of Councilors Moody, Packard, and Best, submitted their nominations for the Editorial Board. Several changes were suggested, after which, upon motion duly made and seconded, the revised list was adopted and the Chairman of the Council was authorized to proceed in accordance with the original resolution providing for the institution of an editorial board. The personnel and officers of the Editorial Board follow:

Chairman of the Board:
George D. Barnett

Executive Committee:
Sumner Everingham, Oakland, Chairman.
Mast Wolfson, Monterey.
Albert J. Scholl, Los Angeles.
George W. Walker, Fresno.
Chauncey D. Leake, San Francisco.

Anesthesiology:
Charles F. McCuskey, Glendale.
H. R. Hathaway, San Francisco.

Dermatology and Syphilology:
H. J. Templeton, Oakland.
William H. Goeckerman, Los Angeles.

Eye, Ear, Nose and Throat:
Frederick C. Cordes, San Francisco.
L. G. Hunnicutt, Pasadena.
George W. Walker, Fresno.

General Medicine:
George D. Barnett, San Francisco.
George H. Houck, Los Angeles.
Mast Wolfson, Monterey.

General Surgery (including Orthopedics):
Frederick C. Bost, San Francisco.
Clarence J. Berne, Los Angeles.
Sumner Everingham, Oakland.

Industrial Medicine and Surgery:
Richard O. Schofield, Sacramento.
Delos Packard Thurber, Los Angeles.

Plastic Surgery:
George W. Pierce, San Francisco.
William S. Kiskadden, Los Angeles.

Neuropsychiatry:
John B. Doyle, Los Angeles.
Olga Bridgman, San Francisco.

Obstetrics and Gynecology:
Erle Henriksen, Los Angeles.
Daniel G. Morton, San Francisco.

Pediatrics:
William A. Reilly, San Francisco.
William W. Belford, San Diego.

Pathology and Bacteriology:
David A. Wood, San Francisco.
R. J. Pickard, San Diego.

Radiology:
R. R. Newell, San Francisco.
Henry J. Ullmann, Santa Barbara.

Urology:
Lewis Michelson, San Francisco.
Albert J. Scholl, Los Angeles.

Pharmacology:
Chauncey D. Leake, San Francisco.
Clinton H. Thienes, Los Angeles.

4. Medical Service by Hospitalization Organizations.

President Wilson suggested that the Chairman of the Council, the Association Secretary, and the Executive Secretary be constituted a committee to meet with the hospitalization groups in California and, through conference, try to bring about a unification of procedures in the matter of medical services, as indicated in the resolution introduced at the 292nd Council meeting; with instructions that in case an understanding was not reached with the hospitalization groups within a period of ninety days, withdrawal of California Medical Association approval would take place, and that members of the Association would be so notified through the OFFICIAL JOURNAL. General discussion followed concerning phases of medical service in hospitals. Further, it was agreed that the committee to be appointed should have power to call in for active aid, California or other experts whom they deemed might be in position to aid in proper settlement of the matters at issue. On motion duly made and seconded, it was voted that the special committee proceed along the lines agreed upon.

5. Indemnification Procedure.

Councilor Packard referred to booklets concerning surgical fee schedules, and it was noted that where indemnification arrangements existed, phraseology such as "the following sums will be applied to the surgical fees to cover surgical services, etc.," be used. On motion by Councilor Packard, seconded by Councilor MacDonald, it was voted that efforts should be made to have indemnification organizations make changes in the wording, to prevent misunderstandings between physicians and patients.

6. Committee Nominations to the House of Delegates.

The special committee, consisting of Councilors Green, Dewey, and Best, submitted the nominations for the standing and special committees. On motion duly made and seconded, the revised list (with Doctor Clough to take charge of Southern California postgraduate work, Dr. Howard R. Madeley of Vallejo to act as vice-chairman of the Advisory Committee on Public Policy and Legislation, and Dr. Norman O'Neil to be chairman on the Committee on Hospitals) was adopted, the list to be submitted for approval to the House of Delegates.

Suggestion was also made that the Council Chairman notify the respective committees and impress upon the members of each committee that they were to feel free to independently inaugurate studies pertaining to their duties, as outlined in the by-laws, and to make reports and recommendations to the Council. It was also agreed that the Sacramento district should have additional representation on the Committee of Public Policy and Legislation.

Revised list of standing committees follows:

STANDING AND SPECIAL COMMITTEES*

COMMITTEE ON ASSOCIATED SOCIETIES

Willard H. Newman, *San Diego*.....1942
John V. Barrow, Chairman, *Los Angeles*.....1943
Edwin L. Bruck, *San Francisco*.....1944

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

Wilton L. Halverson, *Pasadena*.....1942
J. C. Geiger, *San Francisco*.....1943
John C. Ruddock, Chairman, *Los Angeles*.....1944

COMMITTEE ON HISTORY AND OBITUARIES

Jay M. Read, *San Francisco*.....1942
Hyman Miller, *Los Angeles*.....1943
Morton R. Gibbons, Chairman, *San Francisco*.....1944

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

J. Norman O'Neill, Chairman, *Los Angeles*.....1942
Benjamin W. Black, *Oakland*.....1943
Walter Rapaport, *Ukiah*.....1944

COMMITTEE ON INDUSTRIAL PRACTICE

Donald Cass, Chairman, *Los Angeles*.....1942
George H. Sanderson, *Stockton*.....1943
Wilbur J. Cox, *San Francisco*.....1944

COMMITTEE ON MEDICAL DEFENSE

William J. Van Den Berg, *Sacramento*.....1942
Lewis T. Bullock, *Los Angeles*.....1943
Nelson J. Howard, Chairman, *San Francisco*.....1944

COMMITTEE ON MEDICAL ECONOMICS

J. Roy Jones, *Sacramento*.....1942
Edward C. Pallette, *Los Angeles*.....1943
Glenn F. Cushman, Chairman, *San Francisco*.....1944

COMMITTEE ON MEDICAL EDUCATION AND MEDICAL INSTITUTIONS

L. R. Chandler, Chairman, *San Francisco*.....1942
Fred H. Kruse, *San Francisco*.....1943
B. O. Raulston, *Los Angeles*.....1944

COMMITTEE ON MEMBERSHIP AND ORGANIZATION

Dewey R. Powell, *Stockton*.....1942
L. H. Redelings, *San Diego*.....1943
Lewis A. Alesen, Chairman, *Los Angeles*.....1944

COMMITTEE ON POSTGRADUATE ACTIVITIES

H. E. Henderson, *Santa Barbara*.....1942
Dwight L. Wilbur, Chairman, *San Francisco*.....1943
F. E. Clough, Vice-Chairman, *San Bernardino*.....1944

COMMITTEE ON PUBLICATIONS

Francis E. Toomey, *San Diego*.....1942
George W. Walker, *Fresno*.....1943
A. A. Alexander, Chairman, *Oakland*.....1944

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Anthony B. Diepenbrock, *San Francisco*.....1942
E. T. Remmen, *Los Angeles*.....1943
Dwight H. Murray, Chairman, *Napa*.....1944

ADVISORY COMMITTEE

Junius B. Harris, Chairman, *Sacramento*
H. R. Madeley, Vice-Chairman, *Vallejo*.

COMMITTEE ON SCIENTIFIC WORK

Howard F. West, *Los Angeles*.....1942
Fletcher B. Taylor, *Oakland*.....1943
J. Homer Woolsey, *Woodland*.....1944
Secretary, Section on Medicine, ex officio.
Secretary, Section on Surgery, ex officio.
Association Secretary, ex officio, chairman.

COMMITTEE ON PUBLIC RELATIONS

By-laws provide that the chairmen of the following standing committees shall constitute the Committee on Public Relations, the committee electing its chairman:

Roy E. Thomas, Chairman, Committee on Health and Public Instruction.

J. Norman O'Neill, Chairman, Committee on Hospitals, Dispensaries, Clinics.

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* On the standing committees one member is elected each year. Term of service is for three years. Council makes appointments of members and chairmanships, subject to approval by the House of Delegates. At Del Monte on Wednesday, May 7, 1941, committee appointments as listed were approved. Each Standing Committee is authorized to appoint advisory members.

Donald Cass, Chairman, Committee on Industrial Practice.

George G. Reinle, Chairman, Committee on Medical Defense.

George D. Maner, Chairman, Committee on Membership and Organization.

John H. Graves, Chairman, Committee on Medical Economics.

Dwight H. Murray, Chairman, Committee on Public Policy and Legislation.

Dwight L. Wilbur, Chairman, Committee on Postgraduate Activities.

Charles A. Dukes, Chairman, Cancer Commission.

Henry S. Rogers, President of California Medical Association.

William R. Molony, Sr., President-Elect.

George H. Kress, Secretary-Treasurer.

CANCER COMMISSION

Alson R. Kilgore, *San Francisco*	1942
Henry J. Ullmann, *Santa Barbara*	1942
Clarence J. Berne, *Los Angeles*	1942
Charles A. Dukes, *Oakland*	1943
Lyell C. Kinney, *San Diego*	1943
Otto H. Pflueger, *San Francisco*	1943
Orville N. Meland, *Los Angeles*	1944
A. Herman Zeiler, *Los Angeles*	1944
Gertrude Moore, *Oakland*	1944

Cancer Commission elects its chairman and secretary.

7. **Retirement of Past President Dukes.**

Past President Dukes requested the privilege of the floor to express to the members of the Council his deep appreciation of the coöperation that had been given to him in his work as a councilor and general officer.

8. **Vacancies in the Standing Committee.**

Councilor Best called attention to the possibility of members who had been appointed to places on the standing and special committees being called into military service.

It was agreed that the Chairman of the Council, in conference with the Association Secretary, should have power to fill any vacancies that might arise, subject to later approval by the Council.

9. **Vacations for the Association Secretary and Executive Secretary.**

President-Elect Rogers called attention to the fact that, while clerical members of the headquarters office had been given vacations, the present Association Secretary-Treasurer had never been given a vacation since he took up the work in 1938. Councilor Rogers felt that vacation periods should be granted to the Association Secretary and the Executive Secretary on the same basis as other employees, and it was so voted.

PHILIP K. GILMAN, *Chairman.*
GEORGE H. KRESS, *Secretary.*

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IV.—Fourth Meeting at Del Monte

Minutes of the Two Hundred and Ninety-Fourth (294th) Meeting of the Council of the California Medical Association

Meeting was held in the private dining room of Hotel Del Monte, Del Monte, Thursday, May 8, 1941, at 7:30 a. m.

1. **Roll Call.**

Present: Councilors Philip K. Gilman (chairman), Henry S. Rogers, William R. Molony, Sr., Harry H. Wilson, Lowell S. Goin, E. Earl Moody, Elbridge J. Best, Sam J. McClendon, Edward B. Dewey, Dewey R. Powell, Calvert L. Emmons, Louis A. Packard, Axcel E. Anderson, R. Stanley Kneeshaw, Frank Makinson, Frank A. MacDonald, John W. Green, George D. Maner, George H. Kress.

Absent: Councilor John W. Cline (out of state).

Present by request: Messrs. John Hunton, Hartley F. Peart, and Howard Hassard.

2. **Election of Council Officers.**

The meeting was called to order by Chairman Philip K. Gilman, who stated that the first order of business would be the election of a council chairman. Dr. Philip K. Gilman was nominated, and on motion duly made and seconded, put by President Harry Wilson, the Secretary was instructed to cast the ballot for Philip K. Gilman as chairman.

Elbridge J. Best was elected vice-chairman.

3. **Resolution No. 8.**

(This item is referred to in minutes of House of Delegates. Electrically recorded. For minutes of California Medical Association House of Delegates, see June issue, on page 310.)

4. **Resolution No. 9.**

(This item is referred to in minutes of the House of Delegates.)

5. **Resolution No. 10.**

(This item is referred to in minutes of the House of Delegates.)

6. **Committee to Meet with the Industrial Accident Commission.**

(This item is referred to in minutes of the House of Delegates.)

7. **Resolution Nos. 7 and 11.**

(This item is referred to in minutes of the House of Delegates.)

8. **Clerical Aid to Woman's Auxiliary.**

The attention of the Council was called to the request from the Woman's Auxiliary to the California Medical Association in which the need of occasional clerical aid was brought out. It was voted that the facilities of the headquarters office of the California Medical Association should be made available for mimeograph and similar work, insofar as possible; and, in addition, that for such period immediately preceding the annual session a clerical assistant, or special clerical aid, would be made available in the headquarters office to better carry out the work of the Woman's Auxiliary, such arrangement being subject to approval of a special subcommittee, consisting of the Council Chairman and the Association Secretary.

9. **Executive Session.**

The Council then went into executive session, Doctor Kress and Messrs. Hunton and Peart withdrawing from the room.

Councilor Moody was requested to act as secretary of the executive session. Minutes of the executive session as presented by Secretary Moody are as follows:

(*a*) On motion by Doctor Rogers, seconded by Doctor McClendon, Dr. George H. Kress was elected editor for one year, at salary of $4,000 per year.

(*b*) On motion by Doctor Packard, seconded by Doctor Emmons, Dr. George H. Kress was elected Association secretary and treasurer for the coming year, at his present salary.

(*c*) On motion by Doctor Packard, seconded by Doctor Anderson, Mr. John Hunton was elected executive secretary for the coming year, at his present salary.

(*d*) On motion by Doctor Rogers, seconded by Doctor Emmons, Hartley F. Peart, Esq., was employed as legal counsel, on his present retainer fee ($4,000).

(*e*) On motion by Doctor MacDonald, seconded by Doctor Kneeshaw, the special committee on reorganization of the headquarters offices and work, consisting of Council Chairman Gilman, President Rogers and Past President Wilson, was instructed to make a survey of the work and expenses of the Legal Department of the Association, and to make report thereon to the Council.

(*f*) Upon motion by Doctor Best, seconded by Doctor Anderson, it was voted that the Council arise from executive session.

PHILIP K. GILMAN, *Chairman.*
E. EARL MOODY, *Secretary.*

10. Election of Alternate Delegate to American Medical Association House of Delegates.

Dr. Lowell Goin, who has been elected a delegate to the American Medical Association for 1940-1941, stated that neither he nor his alternate, Dr. Roy E. Thomas, would be able to attend the American Medical Association session to be held at Cleveland, Ohio, June 2-6.

On motion duly made and seconded it was voted that Past President Harry H. Wilson should be the alternate at this year's annual session of the American Medical Association House of Delegates, in lieu of Doctors Goin and Thomas.

11. Per Diems of Councilors.

Dr. Dewey R. Powell asked for information concerning the by-law adopted at Del Monte, May 4, 1939 (per insert on page 35, by-laws), relating to expenses of councilors and officers. General discussion followed, it being agreed that any action previously taken by the Council (per item 9074 in Council minutes of June 3, 1939), subsequent to the action of the House of Delegates, would have no mandatory power.

On motion by Doctor Maner, seconded by Doctor Anderson, it was voted, as regards the Del Monte session of year 1941, that the councilors live up to the provisions in the by-laws. Motion was carried, Doctor Maner asking that his vote be recorded, "No."

12. Date of Next Council Meeting.

It was agreed that Chairman of the Council should call a meeting of the Council at such time and place as in his judgment may be deemed advisable.

13. Additional Signature for Checks.

Executive Secretary Hunton suggested that in the absence of the Association Secretary-Treasurer, it would seem advisable that the Executive Secretary be authorized to sign checks, in lieu of the Treasurer. It was so voted.

14. Insurance Principle in the Care of Needy Member.

Councilor Anderson discussed briefly a suggestion that had been made that the insurance principle might be used to good advantage in creating a fund for the care of needy members. He stated the subject would be studied by the Special Committee.

15. Newspaper Publicity.

Attention was called to an article in one of the San Francisco newspapers dealing with the California Physicians' Service, perusal of which could give a wrong impression of the extent to which the prepayment plan, endorsed by the California Medical Association, was being supported by the State Association members.

The difficulties incident to newspaper publicity during the stress and strain of a convention were pointed out.

16. Adjournment.

There being no further business, motion was made to adjourn to meet on call of the Chairman.

PHILIP K. GILMAN, *Chairman.*
GEORGE H. KRESS, *Secretary.*

CALIFORNIA COMMITTEE ON MEDICAL PREPAREDNESS†

California maintained her high standing in the first four months of 1941 in the number of American Medical Association Medical Preparedness blanks filed in Chicago. The report of the American Medical Association Committee on Medical Preparedness, given at the American Medical Association Cleveland annual meeting, shows that California, size considered, had filed a larger percentage of Medical Preparedness blanks than any other large state.

The California Medical Association central office has completed the mailing of Medical Preparedness blanks to all physicians in the state, including osteopaths listed as physicians and surgeons. Incomplete blanks have been prepared for all physicians who did not answer the several calls for this information, and these have been sent to Chicago. A few completed blanks are still being received, but the volume of these is minor compared with some weeks last fall, when as many as 1,000 blanks were received in one week. The following table indicates the number of physicians registered in the larger states, the number of Medical Preparedness blanks filed as of last April 1, and the percentage of returns from each state:

State	Total Physicians	Reported April 1, 1941	Per Cent Reported
New York	28,411	22,590	79.5
Pennsylvania	14,064	10,615	75.5
Illinois	12,683	10,211	80.5
California	12,299	10,480	85.2
Ohio	9,642	8,545	88.6
Massachusetts	8,202	5,632	68.6
Texas	7,056	5,843	82.8
New Jersey	6,070	4,647	76.6

* * *

Physicians and the National Emergency

The "Bulletin of Alameda County Medical Association" printed the following message from the president of the Association, Dr. John W. Sherrick:

Much unjust criticism has been openly expressed by members of the Army Medical Corps against the medical profession and its part in the present emergency. Existing facts do not justify these accusations. This feeling of doubt and mistrust is not held by the Medical Corps of the Navy, which has voiced its gratification and approval of the excellent response shown by its reserve officers and medical specialists units and by the enlisting of other eligible physicians in this branch of national service.

The statement has been made repeatedly from authoritative sources that the Army requires some 7,500 physicians yearly to fulfill its medical needs as planned for the enlargement of the Army. This statement is true, if we assume that there will be a yearly turnover of this number of doctors. As a matter of fact, this will not hold true, as the greater number of the doctors inducted into the Army Medical Corps will undoubtedly be retained in service for the duration of the emergency.

Moreover, reports are available from many of the reserve officers now on active duty with the Army to the effect that there is very little real work available for them to perform. In the face of such a situation, and with civilian needs for medical care so great, many honorable and patriotically minded physicians in civilian practice hesitate to sacrifice their present status until it is demonstrated that there is a more definite and legitimate need for their services.

Again, the criticism leveled against the medical profession fails to give the deserved credit to the thousands of doctors throughout the United States who are giving of their time and of their professional services gratis to the vital work required by the draft inductive boards.

We are justly proud of the record of the members of the medical profession throughout the ages. Based upon previous emergencies that this country has experienced and upon the daily services rendered by physicians in the free clinics throughout the country, etc., we may safely assume that the medical profession will continue to prove true to

†Philip K. Gilman, M. D., 2000 Van Ness Avenue, San Francisco, is chairman of the California Committee on Medical Preparedness. Charles A. Dukes, M. D., 426 Seventeenth Street, Oakland, is a member of the American Medical Association Committee on Medical Preparedness. Roster of county chairmen on Medical Preparedness appeared in CALIFORNIA AND WESTERN MEDICINE, August, 1940, on page 86.

the ideals and the ethics on which it is founded and will not be found wanting in response to the call of our country if the national emergency assumes actual magnitude instead of its present somewhat theoretical significance.

The Alameda County Medical Association, along with similar groups throughout the country, may rest its case in confidence and with justified pride upon its past record and upon the sterling character of its members. We *will not* be found wanting!

* * *

Army to Defer Students of Medicine

San Francisco (AP).—A new plan which will permit junior and senior medical students of Grade A medical schools and interns to complete their training before entering military service was announced yesterday from Ninth Corps Area headquarters.

Major-General Ernest D. Peek, Ninth Corps Area commanding general, said he had received instructions from the War Department that junior and senior medical students may be commissioned first lieutenants in the Medical Corps, with the understanding that they will be ordered to one year's active military duty immediately upon completion of their internship.

Interns and medical students who are appointed reserve officers will not be subject to registration or induction under the Selective Service Act and, therefore, may complete their training, the announcement said.

Applications for reserve commissions from students and interns who live in California, Oregon, Washington, Idaho, Montana, Utah, and Nevada, should be sent to the commanding general, Ninth Corps Area, Presidio of San Francisco.—Sacramento *Union*, June 5, 1941.

* * *

Selectees' Final Medical Examinations Should Be Held Before Induction

"Group examination" of selectees for the United States Army, inaugurated last week in Redwood City and probably in many other communities, sounds like a good solution to the problem of how to save the time of busy physicians who give of their time free of charge when they make examinations of young men about to be drafted.

But—it seems to us this new plan should be accompanied by some changes in the method of giving final medical examinations to the selectees.

Fortunately the Peninsula hasn't had many draftees rejected at the induction center after they had first passed physical examinations in their home towns. But a few have been turned down from this vicinity, and in San Francisco the other day 19 out of 127 men who reported were sent back home.

Each of these nineteen, and others who have suffered a similar fate, had previously made all arrangements to spend a year in camp. They had given up their jobs, severed family ties, perhaps sold possessions, and otherwise gone through a lot of work to get ready to serve their country. Their names had been printed among the list of selectees leaving. Perhaps they had even been given farewell parties.

Then they had to come back home. Their employers had to arrange to take them back to work, which in many cases meant discharging men who had taken their places. They had to suffer the humiliation of explaining why they were at home instead of in the Army.

We have no quarrel with the handling of the examinations by the local physicians. Those doctors are busier than ever now that some of the members of their profession also have been taken into the Army. Certainly they deserve a "break," for the examination of dozens of young men has taken much valuable time of the public-spirited physicians who have agreed to do this work.

But we do think the draft act should be changed to permit all young men to have their final physical examination by Army medical authorities before they sever their civilian ties. Now with "group examinations" being given, even more men than ever may slip by local doctors only to be rejected at the induction center.

The youth who enlists is given seventy-two hours to wind up his affairs after he definitely learns if the Army doctors will accept him. And, recently, draft authorities have permitted men of large business affairs to get an Army medical examination which will indicate whether or not they will be inducted or rejected. The same privilege should be extended to all selectees.—Redwood City *Tribune*, May 26, 1941.

* * *

Outstanding Medical Men Gather in Annual Meeting

With many of the keenest medical minds of the naval and military service present, as well as leading physicians and surgeons of the Pacific Coast, more than two hundred physicians were present last night at a dinner in the Naval Hospital on Mare Island, with naval physicians as hosts.

It was the fourth annual affair staged by the Navy medicos for the physicians of this district, and among the guests were Army and Navy doctors from the San Francisco bay region and all national defense medical centers, as well as members of the Solano County Medical Association.

Dinner was served at eight o'clock, and was followed by an address by Dr. Arthur H. Dearing, chief of the surgical division at the Naval Hospital, Mare Island. Doctor Dearing spoke on field surgery in action, explaining the methods used and the problems which must be solved in the field by military physicians and surgeons.

At the close of Doctor Dearing's talk, motion pictures were shown which gave a detailed account of the medical aspects of landing forces, the establishment of dressing stations, followed by the setting up of clearing hospitals and, finally, base hospitals. Dr. Robert G. Davis, executive officer at the Naval Hospital, was in charge of arrangements for the program.

Many Guests

Among the guests present at the dinner meeting were: Dr. Philip K. Gilman of Stanford University, heading a group of forty physicians who came here last night by chartered bus; a group of thirty United States Army physicians from Letterman Hospital, San Francisco; Dr. Henry Rogers of Petaluma, president of the California State Medical Association; Dr. George H. Kress of San Francisco; Dr. John W. Green of Vallejo, councilor of the Ninth California Medical District; Dr. Dwight W. Murray of Sacramento, public relations counsel for the State Medical Association; and Ben H. Read, secretary of the California Public Health League.—Vallejo *Times-Herald*, June 18, 1941.

* * *

Soldiers Must Think

Modern soldiers must have something more than physical strength and ability to shoot straight. Good physical condition is highly desirable, quite necessary, in fact; but there also must be brains. So says medical authority, after an opportunity to survey today's demands on combative man power. The mental make-up is of first importance. To be able to determine where normality leaves off and disease begins is a test for examiners. "All men are not suited for war service," says one physician experienced in passing on applicants for military duty. "Many men have nervous systems that are not equal to demands."

The whole subject is explored in a symposium conducted for "War Medicine," a new periodical recently created by the American Medical Association and the Division on Medical Sciences of the National Research Council. The topic discussed is "Psychiatric Factors in the Medical Examination." It is said to be imperative that soldiers be mentally fit. Modern warfare has a chief weapon in exaggerated fear, induced by whistling bombs, threats in advance of actual combat, by horrible examples, and by terrifying tales.—Grass Valley *Union*, June 19, 1941.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION†

Regarding Osteopathic Interns in United States Army*

In re: H. R. 4476 (and later Measure H. R. 4965).

H. R. 4476

H. R. 4476 bore the title "A Bill Providing for Sundry Matters Affecting the Military Establishment." As introduced, the only provision of primary medical interest, as stated in Federal Legislative Bulletin—4, page 6, was contained in Section 1, authorizing the Secretary of War:

"to provide for the employment of interns in the Medical Department, at not to exceed $720 per annum."

The bill has now been reported to the House of Representatives in Washington, in an amended form. Under the

† Component County Societies and California Medical Association members should not give endorsements to proposed legislation unless the California Medical Association Committee on Public Policy and Legislation has so requested. On such matters, address: California Medical Association Committee on Legislation, Dwight Murray, M. D., Chairman, 450 Sutter, San Francisco. Telephone, DOuglas 0062.

* For editorial comment, see page 4.

amended bill the Secretary of War will be authorized, the italics being new:

"to provide for the employment of internes *who are graduates of or have successfully completed at least four years' professional training in reputable schools of medicine or osteopathy* in the Medical Department, at not to exceed $720 per annum."

As justification of the employment of interns in the Medical Department, the report of the House Committee on Military Affairs states:

"This will permit the War Department to give certain selected Reserve Officers' Training Corps graduates an additional year of instruction under Medical Corps supervision, thus *insuring a high standard for officer candidates for the Medical Corps.* The proposed rate of pay compares favorably with that paid in civilian hospitals."

General Comment.—The Committee of the House of Representatives does not, in its report, attempt to justify the employment of graduates of osteopathic schools nor can their employment be justified.

Osteopaths are ineligible for appointment as medical officers in the Army Medical Corps and, therefore, the employment of graduates of osteopathic schools as contemplated by the pending bill could serve no possible good purpose. They would not be eligible for appointment in the Medical Corps after being so employed.

H. R. 4965 (HARNESS) IS A SIMILAR MEASURE

It has been passed by the House of Representatives, and is now (June 12, 1941) under consideration by the Committee on Appropriations of the United States Senate (as an amendment to an important appropriations bill).

Comment.—What has been stated above concerning H. R. 4476 applies with equal force to this amendment to H. R. 4965 which was introduced by Representative Harness of Kokomo, Indiana. The soldiers in the United States Army are entitled to medical care of the highest standard. The standard set should apply to all groups of healing-art practitioners. Any other plan will make for confusion and less efficient service.

* * *

Bill Aimed at Alien Doctors Is Okehed

Doctors who are citizens of countries which refuse to admit American physicians and surgeons to practice will be denied the privilege of establishing private offices in California.

This restriction will go on the statute books despite the gubernatorial veto of A. B. 1475, by Assemblyman Roger Alton Pfaff of Los Angeles County. Both houses overrode the veto.

Under the terms of the measure, the alien doctors would be permitted to work in hospitals and research laboratories, however. . . .—Sacramento *Bee,* June 16, 1941.

* * *

Olson Vetoes Curb on Quack Medical Groups

Sacramento, June 4 (INS).—Governor Culbert L. Olson today vetoed the Cain bill, which sought to put further restrictions upon "quack" medical treatments.

Authored by Assemblyman Edward Cain, Sacramento, the measure would have added to statutes against unprofessional conduct the actual practicing of any mode of treatment which tends to deceive the public. Olson said in his veto message.

"There can be no objection to legislation prohibiting a mode of treatment intended to deceive, but my objection to the bill arises out of the language used."

A measure making plainclothes men of the department of motor vehicles bona fide members of the state highway patrol was signed into law by Governor Olson.—Fresno *Bee,* June 4, 1941.

* * *

Assembly Approves Examination Bill

Lower House approval was voted today, 43 to 27, for a bill which would require all cooks, waiters, waitresses, busboys, and domestic servants in California to obtain certificates showing they are free from communicable diseases.

The proposal, A. B. 1570, was introduced by Assemblyman Frederick F. Houser of Los Angeles County. The health certificates could be obtained from the State Department of Public Health, local health agencies or private physicians. Renewals would be required once a year.—Sacramento *Bee,* June 3, 1941.

Olson Signs Bills

Sacramento, June 25 (AP).—Governor Olson has signed a series of legislative bills, including A. B. 1065, by Assemblyman Lee Bashore, Glendora, making it a misdemeanor if a doctor does not treat both eyes of an infant within two hours after birth with a prophylactic efficient treatment.—San Francisco *News,* June 25, 1941.

COMMITTEE ON PUBLIC HEALTH EDUCATION†

Basic Science Initiative

Progress on the proposed Basic Science Law has been rapid in the past few months, and before the next issue of California and Western Medicine goes to press the Committee on Public Health Education expects to have the initial signatures on initiative petition forms in its hands. The adjournment of the Legislature has left the Public Health League of California, which will handle the initiative petition work, free to work on the Basic Science Law, and before long a state-wide program will be under way.

Present plans are for the inauguration of the signature campaign in one county, probably in the southern part of the state. Results in the test county will govern the rest of the campaign and will point out any weak spots in the methods contemplated for this work.

Physicians and dentists will be called upon for the start of the signature work, with members of the Woman's Auxiliary to be brought into the picture a little later as one state-wide unit. Office assistants, nurses, friends, and purveyors in allied lines will also be asked to help in the task of securing the 212,117 valid signatures needed to place the Basic Science Law on the ballot of the next state general election.

Petition forms are already printed, promotional material is ready. From now on, the success of the campaign will depend in great measure on the efforts put forth by the physicians and dentists themselves.

This law has been in the making for the past ten years. It is hoped that all the effort spent on it to date will be amply supported by the work of the profession in the next twelve months in placing the law on the ballot.

* * *

Tehama County Medical Society Has Exhibit at County Fair

The Tehama County Medical Society, Dr. R. G. Frey, President, has arranged for a wonderful exhibit for the attendees at the Tehama County Fair. They have been fortunate in being able to secure the medical exhibit that was shown and well attended and well liked at the Golden Gate Exposition. Also they have been able to secure for this exhibit the cancer film, "Choose to Live." Also they will pass out instructive literature to those visiting the exhibit. At the present time they are making arrangements for other films on medical subjects that they think will be of interest to the people attending the Fair.

The Tehama County Medical Society is composed of the following: Doctors O. T. Wood, Don Thompson, Roderick Thompson, H. H. Beck, R. G. Frey, F. J. Baily, A. H. Meuser, J. H. Belyear, and F. L. Doane.

The Society's exhibit will be in charge of Dr. F. L. Doane and Dr. Roderick Thompson.—Red Bluff *Daily News,* June 12, 1941. (See also editorial comment, on page 2.)

† The Committee on Public Health Education was established through Substitute Resolution No. 6 at the Del Monte annual session, May 3, 1939.

The Committee on Public Health Education consists of Frank R. Makinson, chairman, Oakland; Philip K. Gilman, secretary, San Francisco; Samuel Ayres, Jr., Los Angeles; Thomas A. Card, Riverside; James F. Doughty, Tracy; Lowell S. Goin, Los Angeles; Junius B. Harris, Sacramento; Henry S. Rogers (ex officio), Petaluma. Communications to the committee may be addressed to Frank R. Makinson, M. D., chairman, Wakefield Building, Oakland, or to the California Medical Association office, 450 Sutter Street, San Francisco.

California Fairs—Tentative Dates for 1941*

Serial No.	Dates Held	Inclusive Days	County (Name)	Place Held	Fair Secretaries
1	Mar. 1- 9	Sat.-Sun.	Imperial County Mid-Winter Fair	Imperial	D. V. Stewart
2	13-23	Tu.-Sun.	National Orange Show	San Bernardino	William Starke
3	May 16-18	Fri.-Sun.	Solano County Fair	Dixon	M. E. Morgan
4	16-18	Fri.-Sun.	Calaveras County Fair	Angels Camp	Joseph Rydberg
5	22-25	Thu.-Sun.	Butte District Fair	Chico	Mrs. Sylvia Cooke
6	30-June 1	Fri.-Sun.	Mariposa County Fair	Mariposa	George W. Robinson
7	June 12-14	Thu.-Sat.	Tehama County Fair	Red Bluff	Jens C. Petersen
8	20-22	Fri.-Sun.	Placer District Fair	Auburn	Ray Carlisle
9	July 3-12	Thu.-Sat.	Alameda County Fair	Pleasanton	Ernest Schween
10	4- 6	Fri.-Sun.	Silverado Fair and Horse Show	Calistoga, Napa County	Frank Piner
11	17-20	Thu.-Sun.	Napa County Fair	Napa	Harrison Cutler
12	23-27	Wed.-Sun.	Santa Barbara County Fair	Santa Maria	J. H. Chambers
13	25-27	Fri.-Sun.	Sonoma-Marin Fair and American Legion Horse Show	Petaluma	Dolph Young
14	30-Aug. 3	Wed.-Sun.	Sacramento County Fair	Galt	E. Kenefick
15	Aug. 1- 3	Fri.-Sun.	Stanislaus County Fair	Oakdale	E. W. Zimmerman
16	2- 9	Sat.-Sat.	Sonoma County Fair	Santa Rosa	Ralph H. Brown
17	8-10	Fri.-Sun.	Placer County Fair	Roseville	H. A. Crockard
18	8-10	Fri.-Sun.	Contra Costa County Fair	Antioch	Alden Sutton
19	11-16	Mon.-Sat.	Stanislaus District Fair	Turlock	Dr. A. J. Ronsse
20	12-17	Tu.-Sun.	Humboldt County Fair	Ferndale	Dr. J. N. D. Hindley
21	14-17	Thu.-Sun.	Plumas County Fair	Quincy	W. P. Cowan
22	16-24	Sat.-Sun.	San Joaquin County Fair	Stockton	E. G. Vollmann
23	21-24	Thu.-Sun.	Nevada County Fair	Grass Valley	Loyle Freeman
24	21-24	Thu.-Sun.	Butte County Fair	Gridley	V. W. Tull
25	22-24	Fri.-Sun.	Mendocino District Fair	Ukiah	Norman G. Buhn
26	23-24	Sat.-Sun.	Trinity County Fair	Hayfork	J. D. Rourke
27	29-Sept. 7	Fri.-Sun.	California State Fair	Sacramento	Kenneth R. Hammaker
28	30-Sept. 1	Sat.-Mon.	Lake County Fair	Lakeport	H. G. Crawford
29	30-Sept. 1	Sat.-Mon.	Siskiyou County Fair	Yreka	W. L. Kleaver
30	Sept. 4- 7	Thu.-Sun.	Modoc County Fair	Cedarville	J. Ray Golden
31	11-13	Thu.-Sat.	Shasta District Fair	Anderson	Dudley Saeltzer
32	11-14	Thu.-Sun.	Merced County Fair	Merced	J. J. Uhle
33	12-14	Fri.-Sun.	El Dorado County Fair	Placerville	John Winkelman
34	12-14	Fri.-Sun.	Amador County Fair	Plymouth	Mrs. Goula Wait
35	12-28	Fri.-Sun.	Los Angeles County Fair	Pomona	C. B. Afflerbaugh
36	16-20	Tu.-Sat.	Glenn County Fair	Orland	J. J. Flaherty
37	17-21	Wed.-Sun.	Del Norte County Fair	Crescent City	C. A. Cronkhite
38	18-21	Thu.-Sun.	Sutter-Yuba Fair	Marysville	J. A. Fredericks
39	18-21	Thu.-Sun.	San Mateo County Fiesta	San Mateo	Chester Lipman
40	19-21	Fri.-Sun.	Tuolumne County Fair and Horse Show	Sonora	Mrs. Francis Graham
41	19-21	Fri.-Sun.	Yolo County Fair	Woodland	Harry Crego
42	22-27	Mon.-Sat.	Tulare-Kings County Fair	Tulare	A. J. Elliott
43	24-28	Wed.-Sun.	Humboldt District Fair	Eureka	Randolph Smith
44	25-28	Thu.-Sun.	Monterey County Fair	Monterey	V. V. Adams
45	25-28	Thu.-Sun.	Colusa County Festival	Colusa	Daniel E. Weygand
46	30-Oct. 5	Tu.-Sun.	Fresno District Fair	Fresno	T. A. Dodge
47	Oct. 4-12	Sat.-Sun.	San Diego County Fair	Del Mar	D. A. Noble
48	4-12	Sat.-Sun.	Santa Clara County Fair	San Jose	Russell Pettit
49	8-12	Wed.-Sun.	Ventura County Fair	Ventura	John Lagomarsino
50	9-12	Thu.-Sun.	Madera County Fair	Madera	H. J. Bunce
51	10-12	Fri.-Sun.	San Benito County Fair	Hollister	J. M. Leonard
52	16-19	Thu.-Sun.	Santa Cruz County Fair	Watsonville	M. W. Johnson

* The above outlines a tentative list of State and County Fairs, with dates: Legends for days: Mon.—Monday; Tu.—Tuesday; Wed.—Wednesday; Thu.—Thursday; Fri.—Friday; Sat.—Saturday; Sun.—Sunday.

The "days" given in this list are the first and the last days of the dates noted (without regard to whether days cover more than one week).

For editorial comment concerning Fairs, see page 1.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (29)

Los Angeles County (8)

Frank S. Bissell, *Los Angeles*
Ralph Culbertson Cloninger, *Los Angeles*
Fridolin Hammerly, *Los Angeles*
John I. Litwinenco, *Pomono*
Olin Paul, *North Hollywood*
Frederick C. Schlumberger, *Los Angeles*
Paul Franklin Seitter, *San Fernando*
W. Benjamin Stewart, *Los Angeles*

Marin County (2)

Brooks Pringle, *San Anselmo*
Katherine Thomas, *San Anselmo*

Merced County (1)

Laurence E. Smith, *Merced*

Orange County (1)

Elmo Alexander, *Fullerton*

Sacramento County (2)

Laura Levinson, *Sacramento*
John G. Walsh, *Sacramento*

San Bernardino County (2)

O. J. Johnson, *Colton*
Miller Harold Randall, *Chino*

San Francisco County (4)

Phyllis Harroun, *San Francisco*
Earl Roy Miller, *San Francisco*
Albert John Porporato, *San Francisco*
Thomas Haynes Roberts, *San Francisco*

San Joaquin County (2)

H. C. Petersen, Jr., *Stockton*
Hildegard L. Waasa, *Stockton*

San Mateo County (3)

H. A. Clattenburg, *Redwood City*
Francis N. Hatch, *Redwood City*
W. B. Hurlbut, *San Mateo*

Santa Barbara County (1)

Woodrow W. Schmela, *Santo Barbara*

Santa Clara County (2)

Robert D. Lane, *San Jose*
Howard William Lytle, *San Jose*

Yolo County (1)

James L. Porter, *Woodland*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

Transfers (4)

Gilbert S. Coltin, from San Luis Obispo County to San Bernardino County.

Vernon E. Greer, from Butte-Glenn County to Sacramento County.

Lester S. McLean, from Riverside County to San Bernardino County.

Middleton P. Stansbury, from Solano County to Yolo County.

Retired Members (12)

Richard W. Baker, Sunland
Willoughby G. Dye, Los Angeles
Edgar James Farrow, San Diego
William C. Finch, Los Angeles
William A. George, Loma Linda
Michael W. Kapp, San Jose
Ross C. Martin, San Bernardino
Truman A. Parker, La Jolla
Minnie A. Seavey, Sacramento
Peter M. Suski, Los Angeles
Emma K. Willits, San Francisco
Frank A. Yoakam, Moorpark

In Memoriam

Freytag, Charles Fred. Died at Hollywood, June 11, 1941, age 59. Graduate of Rush Medical College, University of Chicago, 1905. Licensed in California in 1923. Doctor Freytag was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✝

Hablutzel, Charles Edward. Died at San Jose, May 31, 1941, age 76. Graduate of Cooper Medical College, San Francisco, 1895. Licensed in California in 1895. Doctor Hablutzel was a retired member of the Santa Clara County Medical Association, the California Medical Association, and a member of the American Medical Association.

✝

Hanlon, Edward William. Died at San Francisco, June 3, 1941, age 69. Graduate of Columbia University College of Physicians and Surgeons, New York, 1893. Licensed in California in 1894. Doctor Hanlon was a member of the San Francisco County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

McArthur, Duncan Donald. Died at Los Angeles, May 30, 1941, age 69. Graduate of University of Southern California School of Medicine, Los Angeles, 1905. Licensed in California in 1907. Doctor McArthur was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✝

Schmelz, Charles Joseph. Died at Guerneville, June 2, 1941, age 76. Graduate of University of California Medical School, Berkeley-San Francisco, 1895. Licensed in California in 1895. Doctor Schmelz was a retired member of the Sonoma County Medical Association, the California Medical Association, and a member of the American Medical Association.

OBITUARY

Alfred William Macpherson

1901–1941

Doctor Macpherson was graduated from the College of Medical Evangelists in 1929. He received special training in anesthesiology at the University of Oklahoma Hospital, Oklahoma City. At the time of his death he was assistant professor of anesthesiology at the College of Medical Evangelists and an active staff member in his chosen line at the White Memorial Hospital.

Doctor Macpherson was a member of the Los Angeles County Medical Society, the California Medical Association, the American Medical Association, the International Anesthesia Research Society, and the American Board of Anesthesiology.

Doctor Macpherson died on June 18, 1941, at the age of 39 years, 9 months. Death was caused by complications following surgery for a chronic intestinal ailment.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. HARRY O. HUND.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM.....Asst. Chairman on Publicity

Address of President*

The Woman's Auxiliary to the California Medical Association deeply appreciates the opportunity granted the president to appear before your general session and to tell you something about the activities of our organization.

Existing now for the past twelve years, we are steadily increasing in membership, in activities, and we hope, in influence.

"Preparedness to Better Serve Humanity" has been the theme chosen for our slogan.

We believe that, at the present time when medicine is under attack by the Government, and threatened with regimentation despite the United States' maintenance of the highest health record in the world, we can best serve our parent organization by stressing public relations and public health activities.

As stated in our Constitution, Article 2: "The first objective of the Woman's Auxiliary is to interpret the aims of the medical profession to other organizations interested in the promotion of health education."

To be able to do this, we ourselves must be informed. The majority of our monthly programs, therefore, are planned for self-education, that our objectives may be more completely fulfilled.

We believe that, if we can assist in promoting a better understanding with the public, we have justified our organization.

The majority of you are our friends and well-wishers, and realize the service possibilities of the Auxiliary.

To that small minority, however, who, by not fully realizing the coördination of the Woman's Auxiliary with the California Medical Association, are keeping us from

† As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Rossner Graham, Assistant Chairman on Publicity, 6101 Acacia Avenue, Oakland. Address of the Chairman on Publicity: Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont.

For roster of officers of state and county auxiliaries, see advertising page 6.

* Address given at the first general session of the seventieth annual session of the California Medical Association, Del Monte, May 5-8, 1941.

organizing those last eleven counties in California, we are presenting the following list of our achievements:

Your House of Delegates, in session here at Del Monte in 1937, unanimously voted for the formation of an Auxiliary to every county medical society. Nevertheless, we have been told that the doctor's wife's place was in the home answering the telephone while her husband goes to medical society meetings. Were that true, you know that you would find us deadly dull after awhile. We have been accused of being nothing but a political lobby!

In addition to stressing need for self-education, there has been an earnest endeavor to make ourselves more useful by promoting greater friendliness and better understanding among our members. The result is, our membership has grown 8.6 per cent.

Subscriptions to *Hygeia* have increased 39.6 per cent, and 300 copies being placed each month in public places.

The sum of $100 has been contributed toward the purchase of a movie projector, so that the doctors in a certain county could present medical and health programs before groups of laymen.

We hold membership in the Public Health League to keep better informed on legislation affecting medicine; and we also belong to the League of Women Voters that we may be able to use our influence against candidates hostile to medicine.

We have membership and chairmanships on public relations committees in various clubs to enable us to influence the types of programs presented.

Five subscriptions to *Readers Digest* in Braille have been purchased.

Five scholarships for worthy medical students are provided annually.

One scholarship is made possible annually for a worthy girl in nursing training.

Public speaking contests on health subjects in high schools and junior colleges are helping to make our youth health conscious.

We have responded whole-heartedly to Dr. Philip Gilman's request for assistance on the Medical Preparedness questionnaire. The members of one county made 2,000 telephone calls.

Some 596 Parent-Teacher Association members were contacted by one Auxiliary and medical speakers were supplied to the majority of them.

Twenty-one Auxiliaries are aiding in Cancer Control projects, and every one of the twenty-eight Auxiliaries has provided speakers and health material for lay groups.

Five Auxiliaries have held all-day health conferences.

One county Auxiliary has developed a "Medical Information, Please" panel which presents medical information to lay groups in a most successful manner. This has been one of the outstanding public relations projects of the year.

Many counties have had "Reciprocity Teas." From 200 to 500 persons have attended each of these affairs and listened to a well-qualified medical speaker. You can easily see that such activities have brought about the necessity of developing some orators among you doctors.

Some 2,400 hours of work have been given to the Red Cross, and $800 has been raised for the British Relief, and 10 cases of medical instruments and equipment collected.

Two Hearing Aids for a school, and an Infant Resuscitator for a hospital have been purchased.

In addition to these activities, we have undertaken to raise funds for medical benevolence, and so far this year, $1,600 has been secured.

Annual physical examinations for doctors' wives have been advocated by those who believe that, by setting the example, many of the laity will follow our example and avoid some of the common tragedies of youth and middle age, such as tuberculosis and cancer.

We have promoted district meetings, bringing together officers, prospective officers and members for round-table discussions, and a symposium on "How to Improve the Auxiliary."

We are most appreciative and grateful for the help and guidance received from the Advisory Council.

Whatever we may have accomplished, we have tried to have "tolerance for the ideas of each and every group of individuals, charity for our neighbors, and a unity of purpose in our auxiliary life as we have striven to attain our goal of usefulness to our National, our State, and our County Medical Association." In the words of the president of our youngest Auxiliary, "We feel that, with this foundation, we can accomplish anything we set out to do."

Respectfully submitted,

Mrs. A. E. Anderson, *President.*

* * *

News Items

Mothers of doctors and members were honored at a luncheon meeting, held at Claremont Country Club on May 16 by Alameda County. A report of the State Convention was given by Mrs. Carson Hunt. Mrs. Ira Church, who concluded a very successful year as president, presided, and gave a report of the activities and accomplishments of the organization. After the installation of officers, the meeting was turned over to the new president, Mrs. Abbott Crum, who addressed the group. Entertainment was provided by Alice Weaver (Mrs. Don Weaver) in a play reading.

* * *

Mrs. Ralph B. Eusden, retiring president of the Los Angeles County Auxiliary, presided at the final luncheon meeting of the year. On behalf of the Auxiliary, Mrs. Eusden presented a framed scroll to Mrs. James Percy in recognition of her myriad services. An address was given by Dr. William Molony, Sr. Mrs. William C. Boeck, incoming president, and her board were inducted into office at an impressive ceremony conducted by Mrs. Percy.

* * *

Rio Del Mar Country Club was the setting for the May meeting of Santa Cruz County. Doctors' wives from Camp McQuaide were guests. A book review, "Life With Father," was presented by Mrs. Frank Cralle.

R. V. C.

CALIFORNIA PHYSICIANS' SERVICE†

BENEFICIARY MEMBERSHIP

September, 1939	1,220
March, 1940	9,322
September, 1940	17,398
March, 1941	24,107
June 20, 1941	28,000

* * *

Dr. Frank R. Makinson of Alameda County has resigned as a trustee of California Physicians' Service due to pres-

†Address: California Physicians' Service, 333 Pine Street, San Francisco. Telephone EXbrook 3211. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the Official Journal is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

sure of work and additional responsibility placed upon him by his election as councilor for the California Medical Association. Dr. Clifford W. Mack of Alameda County has been appointed to fill the vacancy and will serve until the next regular meeting of administrative members.

* * *

As a result of the action of the Council of California Medical Association at Del Monte, component county medical societies are naming personnel of committees to coördinate with California Physicians' Service. According to the wording of the resolution, "The function of these committees shall be to contact the Board of Trustees of the California Physicians' Service for the purpose of bringing to their attention the various reactions of the plan from their respective committee areas and to offer such assistance as may be useful to or necessary for the furtherance of the plan as it stands, or to offer such suggestions as may be considered pertinent to the modification of the plan, as instructed by their respective committee areas."

To further the work of these committees, the Board of Trustees of California Physicians' Service has requested the Secretary to develop within the California Physicians' Service office a uniform system of monthly progress reports for regular transmittal to the secretaries of county medical societies and through these secretaries to the chairmen of the local county coördinating committees. It is hoped that the secretaries of the local county medical societies will make a place on the regular agenda of the society for a report on California Physicians' Service.

The Board of Trustees of California Physicians' Service is anxious to work closely with such committees and is hopeful that they will serve as successful liaison groups between the members of the medical profession and the organization created by it, California Physicians' Service.

* * *

During the month of March, 1,926 professional members of California Physicians' Service saw 4,996 patients, making a total of 14,124 visits. This represents 26,317.7 units of service, of which 16,311.7 were medical, 4,868.0 were surgical, 3,109.9 were x-ray, 1,895.7 were laboratory, and 132.4 were refractions.

* * *

M. D. Group Aid Studied by Junior Bar

Meeting Thursday Will Consider Physicians' Plan

Thursday evening at five the Junior Barristers of the Los Angeles Bar Association are holding a general membership meeting in the cafeteria room of the Title Insurance & Trust Company Building, to consider joining the California Physicians' Service. The Barristers Club, corresponding group in San Francisco, joined some time ago.

This plan, which was recommended by the Junior Barristers Committee on Group Medical Insurance as best adapted to the needs of the young professional man, is carried on by a group consisting of substantially all the physicians and surgeons in the State of California.

California Physicians' Service is unique in that it maintains the ordinary private doctor payment to be made on an insurance basis, at the rate of $1.70 per month per member, with full hospitalization being afforded in almost any hospital the member may choose for an additional 80 cents per month.

The patient is known under the plan as a beneficiary member and is treated by any doctor he may choose from the panel of five thousand or more M. D. members.

The beneficiary member's life goes on just as it did before as regards medical attention, except that he lives with the pleasant feeling that medical expense is now a definitely fixed and budgeted item set at a comfortably low figure.

Beneficiary membership is limited to persons with incomes below $3,000 per year since the program was instituted for the sociological purpose of aiding persons in the lower-income brackets.

A representative of the California Physicians' Service will be present at the Thursday meeting to explain the plan in full and to answer the questions which such a proposal may suggest to legal minds. The members are urged to turn out en masse, for their committee feels the plan could be worth enough to the individual members to deserve a full and fair hearing.—Los Angeles *News*, June 23, 1941.

Alcoholic Polyneuritis Cases Not Aided by Extra Vitamins.—"The average time spent in the hospital by patients suffering from alcoholic polyneuritis [inflammation of many nerves at once] who were discharged as well, improved, or relieved was the same regardless of whether the routine house diet or intensive vitamin therapy [treatment] in addition was prescribed," Dr. Madelaine R. Brown, Boston, reports in *The Journal of the American Medical Association*. "The economic aspect of this conclusion is apparent," she adds.

Her findings are based on a study of 236 patients with uncomplicated alcoholic polyneuritis, half of whom received the regular hospital diet and the other half intensive vitamin treatment. In the introduction of her paper, she says:

"No subject today is possessed of more ramifications or is more colored by emotion than vitamins. Too many recent publications are based on a small uncontrolled series of patients and a large amount of wishful thinking. In the evaluation which follows, no opinion is offered as to the part vitamins play in the etiology [cause] or in the treatment of alcoholic polyneuritis. The question is not whether vitamins are necessary in the treatment of polyneuritis, but how much of these substances regenerating neurons [nerve cells] can utilize. Can they utilize more than are present in a diet adequate for a healthy person? In the hope of shedding light on this question, some figures on ward patients receiving the house diet are compared with those on patients receiving intensive vitamin therapy. It should be emphasized that the house diet is not deficient, that it is adequate in all vitamins and that it is a far better diet than that to which the majority of patients in the Boston City Hospital have been accustomed."

There was no significant difference in the time spent in the hospital by the two groups of patients who had mild or moderate degrees of polyneuritis, she found.

"The results obtained among patients with severe or very severe neuritis," Doctor Brown points out, "are of little value, regardless of the type of therapy, since severe nerve degeneration has taken place and regeneration is a matter of many months."

Her study was based upon the records of the Boston City Hospital during the years 1920 through 1938. This period, she says, "was chosen because patients admitted in the first half of this period, that is 1920 to 1929, were given routine house diet with no additional vitamins, whereas the group admitted in the years 1930 to 1938 received exactly the same treatment as the first group, with the exception that the house diet was supplemented by vitamins in the form of fruit juices, egg nog, salad, cod-liver oil and vegex or brewers' yeast tablets. In addition, some of these patients were given parenteral injections of liver extract and thiamin [synthetic vitamin B_1], thus affording a comparison of the efficacy of the whole vitamin B group in the therapy of polyneuritis associated with chronic alcoholism."

When to Clean the Teeth.—For maximum effectiveness, teeth should be brushed directly after meals, *Hygeia, The Health Magazine* points out. Scientific reports indicate that the conversion of refined carbohydrates to acids through action of bacteria in the mouth may be surprisingly rapid. These acids are responsible for the initial phase of tooth decay. Certain soft deposits which later harden to form the substance known as calculus also are more easily removed directly after meals than at a later time.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Stanford Symposium: Harvard Physiologist Urges Medical Attack on Disabilities Accompanying Old Age. A medical attack on the diseases and disabilities of old age, which have been given new importance by the advancing age level of the general population, was proposed at the Stanford symposium yesterday by Dr. Walter B. Cannon, Harvard University physiologist, in a review of problems confronting the medical profession.

"Almost none of the most prominent disorders of senescence is understood," he said. "The prevailing ignorance, we may assume, is largely due to lack of systematic study.

"Death, of course, must come when one or another vital organ fails its duties, but while life lasts no effort should be spared to make it a good life.

Many Triumphs.—Medical science, Doctor Cannon said, has achieved many a "beneficent triumph" over such diseases as typhoid fever, diphtheria, pellagra, tuberculosis, malaria, yellow fever, hookworm infections and child-bed fever, but it knows much less about diabetes, cancer, hardening of the arteries and other diseases attendant upon advancing age.

Still less, he said, has it done toward conquering calamities of old age that may not kill, but sorely torment, such as rheumatism, chronic inflammation of the bronchial tubes, asthma, persistent itching, "which can render the period of senescence wearisome and miserable."

The importance of attacking these diseases, Doctor Cannon said, comes from the advancing age level of the population because of a decreased birth rate on one hand and a greatly increased life expectancy, largely as a result of medical science, on the other. By 1980, under the present trend, 14 per cent of the population of the United States will be 65 or older—22 millions instead of the 3 millions of forty years ago, he said.

Study Mechanism.—As a foremost subject of study, Doctor Cannon suggested the mechanism which keeps the body's life fluids in delicate balance.

A second new problem presented as a result of the changing social structure, he said, is that of the increase of nervous disorders, manifested by increased insanity, and rate of suicide.

"The ways in which the processes of the brain produce disturbances are little comprehended and the devices which might be employed for prevention or cure have not received the scientific attention which their importance demands," he said. "In the great asylums custodial care continues to be almost the only type of treatment. And meanwhile the problem grows constantly greater and more startling."

The study of drugs and their use in healing is another great and insufficiently explored field challenging medicine, Doctor Cannon asserted.

Drugs Important.—Modern miracles such as the cure of types of insanity, the banishing of diphtheria, the conquering of anemia, have been achieved through the use of drugs, yet "in about a third of the medical schools of the United States there is no independent department devoted to the experimental study of the action of drugs and their use in treating disease."

That these problems be attacked in America becomes more important because of the war in Europe, Doctor Cannon said.

"It seems probable," he declared, "that for years to come the need to repair the wreckage and the appalling waste resultant from the present titanic strife will leave European nations in such poverty that scientific studies will be sadly slighted."

A final problem, Doctor Cannon concluded, is that medical investigators must see to the filling of their own ranks, that the advantages that medical research possesses over general practice be made known to students.—Palo Alto *Times,* June 19, 1941.

Colleges Plan Faster Pace.—To give students complete college educations before they are called for military service, between 400 and 500 liberal arts colleges this fall will offer three-year programs to replace the standard four-year courses.

Summer vacations and holidays will be cut to a minimum, Dr. Guy E. Snavely, executive director of the Association of American Colleges, said recently in disclosing the plan.

Doctor Snavely said the theory behind the plan is that young men entering college at eighteen—the average age for college entrance—will have completed their college education by the time they have reached draft age. Younger students will not be encouraged to take the speed-up course.

In operation, the plan means that students will attend three terms each year instead of two. Many colleges are making arrangements for twelve-week summer sessions instead of the usual six weeks. More than one hundred will introduce summer courses for the first time next month.

Faculty members will be on call the year round, at least for the duration of the emergency.

He said many institutions are threatened with enrollment losses because of the draft and the volunteering of many students. He declared he believes that the three-year program may be the only way for many small liberal arts colleges to continue in existence.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Medical Association Critics Are Scored

Cleveland, June 3 (AP).—The American Medical Association was exhorted to defend its policies against "destructive criticism by authors whose mental processes seem to have been influenced by Moscow or Berlin."

Retiring President Nathan B. Van Etten of New York accused certain "special interest groups of attacking the American Medical Association as 'a selfish, reactionary, anti-social, restraining influence, opposing activities of those desiring to practice group medicine.'

"The old idle talk about a small group of persons dictating the policy of the American Medical Association still goes on," he declared before the American Medical Association House of Delegates at the opening of the Association's ninety-second annual meeting.

He reported three American Medical Association executives have been called a "triumvirate of dictators," and identified the three as Dr. Olin West, treasurer; Dr. Morris Fishbein, editor; and Dr. Will C. Braun, business manager, of the Journal of the American Medical Association.

"I have never heard or seen any of them attempt to originate any policy," he commented.

A survey showing 95 per cent of the nation's physicians willing to support military service was cited as evidence of the Association's integrity.

The Association's controversial policy of "free choice of physician" was reported to have stood the test of seven turbulent years.

The House of Delegates was called upon to fight for establishment of a national health department to be headed by an officer of cabinet rank.—Fresno *Bee*, June 3, 1941.

* * *

Doctor Dukes Elected Vice-President of Medical Association

Dr. Charles A. Dukes of Oakland, a long-time leader in the affairs of organized medicine, is the new vice-president of the American Medical Association.

He was selected yesterday afternoon at the convention of the American Medical Association in Cleveland, according to an Associated Press dispatch.

Doctor Dukes retired a year ago as president of the California Medical Association. He has been vice-president of the American College of Surgeons and president of the Alameda County Medical Society.—Oakland *Tribune*, June 6, 1941.

* * *

Sickness and Accidents Are Defense-Effort Foes

Dr. Thomas Parran, Surgeon-General of the United States, declared at a recent meeting of the American Medical Association that it is high time the nation endeavored to make her man power as good as her machines.

The latter rarely break down, but the former do so with slight provocation. Doctor Parran says there were 350,000,000 man days lost in 1940 because of illness and industrial accidents. That is equivalent to 1,000,000 men working a full year. And if 10 per cent of this loss could be prevented it would be sufficient to build twelve cantonments of average size or five battleships or 16,407 combat tanks.

The country should not remain complacent concerning this loss of labor power at a time when national defense calls for the utilization of every bit of available skill because a day's work lost through sickness or preventable accident is gone forever.

That is sufficient reason why every man should do all in his power to guard himself against disease and to preach and practice safety. He owes it to himself and to his country.—Fresno *Bee*, June 18, 1941.

* * *

Modern Medicine

(*This is the first of a series of articles on some of the ideals and objectives of modern medicine, as defined by the San Francisco County Medical Society.*—The Editor.)

The United States, living under its free enterprise system of government—and of medicine—has the lowest death rate in the world today, a report released by the San Francisco County Medical Society declared today.

"The free enterprise system of the United States permits any man to go as far as his abilities will take him," the report stated.

Free Enterprise Praised

"All of us know what this free enterprise system has produced. It has given us the highest standard of living in the world. It has given the typical worker a higher paid job and a shorter work-week than is known anywhere else. It has given the average man and woman more of the luxuries and necessities than their counterparts enjoy in any other nation. It has given them more security, in the form of homes, insurance, bank deposits and other forms of saving.

"All of this has been done under that free enterprise system—the individualistic system, so to speak. And that system has given us more than goods and chattels. For example, in the field of medicine we can see again what private enterprise achieves.

United States Deaths Far Fewer

"In 1936 there were 11.5 deaths per each 100,000 of population from diphtheria in Germany. There were 8.6 in England. There were but 1.5 in the United States. There is one qualified physician for each 767 people here—as against one for each 1,069 in England, one for each 1,307 in Germany, and one for each 1,596 in France. In the totalitarian states, where Government dominates medicine, and the bureaucrats pick the doctors, almost all diseases are increasing. Here all are decreasing—and rapidly.

"So does American medicine, like American industry, serve. It is private medicine—it is 'free enterprise medicine.' No other system ever devised by man has done so much for the great masses of the people."—San Francisco *News*, April 22, 1941.

* * *

Bacteriophage

A "Cure-All" Loses Prestige

Twenty-five years ago bacteriophage was the answer to the physician's prayer.

It was the "littlest germ," able to destroy larger germs, and it was going to cure every microbe-caused disease from anthrax to zygomycosis. Optimistic writers prophesied the complete eradication of typhoid fever, cholera, plague, blood poisoning, pneumonia.

That was twenty-five years ago.

Yesterday, Dr. Albert Krueger of the University of California, one of the world's most distinguished authorities on bacteriophage, said the "tiny bacteria slayer" might some day find use in the treatment of dysentery and cholera. But for the others—definitely no.

In a survey published by the American Medical Association, he and Dr. Jane Scribner showed most of the proposed uses of bacteriophage have been ruled out by careful research.

So small that it is invisible under an ordinary high-powered microscope, bacteriophage can probably be detected with the new electron-microscope.—M. M. S.—San Francisco *Chronicle*, June 1, 1941.

* * *

Council Hears Anderson Tell "Prepay" Plan

A proposal to establish an organization in San Jose, with members securing low-cost medical service under a prepayment plan was outlined to delegates of the Central Labor Council last Friday night by Dr. E. T. Anderson, local physician. Anderson is contacting key union labor organizations in an effort to secure support of the plan.

Tentative arrangements provide home and office medical service at a basic rate of 60 cents per month per member, with flat reduced rate for prescriptions. Several hundred members will be required to launch the Association, Doctor Anderson told the delegates. Asked about hospitalization and major surgical service in connection with such a plan, Anderson said that this type of extended service could be added when the preliminary form of organization had been launched successfully.

Doctor Anderson is a brother of Dewey Anderson, former Assemblyman of Santa Clara County and now a key member of the well-known Temporary National Economic Committee whose report on national social and economic conditions is one of the recent highlights of the Roosevelt Administration.—San Jose *Union Gazette*, May 30, 1941.

* * *

Health in Defense

Doctors, scientists, economists, and social welfare experts recently wrestled for three days in a conference at Washington, D. C., called by the President to consider the replacing of vitamins in food which had been "refined out" of it.

Chairman Paul V. McNutt of the nutrition conference declared that we have "failed to keep up a steady flow of dairy products, meats, fruits, and vegetables from the farm to the city tables," and it is time to do something about replacing in certain foods the nutriment that has been taken out of them.

For instance, Dr. James A. Crabtree, medical and nutritional expert, declares that, while bread is the backbone of most American diets, it is not a true staff of life.

"Flour refinement," he says, "has removed virtually all the vitamins and left only a bland-tasting starchy chaser for hamburgers and such."

Sugar, he asserts, has been reduced by refinement to a mere fire in which to burn proteins.

It will be the aim of the Government experts to treat sugar to "a vitamin injection" and so return it to its former position as a food as well as a fire.

It should be said that this "minus vitamin" condition is not the fault of anybody in particular, as the changing tastes of the American people have been accompanied or met by the processors of foods, and the missing vitamins can be and will be replaced without changing the taste and appearance of the foods to which they are added.

It is the hope that through women's organizations, Parent-Teacher Association circles, visiting nurses, family physicians, schools and colleges, clinics, radio, the lecture platform and the press, the people may be awakened to the necessity of coöperating in this health movement as a necessary concomitant to the national defense.

Everyone should coöperate, at least. A healthy citizen is the first line of any country's defense.—Editorial in San Francisco *Call-Bulletin*, June 25, 1941.

LETTERS†

Concerning Graduates of Foreign Medical Schools.

(COPY)

AMERICAN MEDICAL ASSOCIATION
BUREAU OF LEGAL MEDICINE AND LEGISLATION
J. W. HOLLOWAY, JR., ACTING DIRECTOR

Chicago, May 13, 1941.

Hon. John F. Shelley,
California Legislature,
State Capitol,
Sacramento, California.

My dear Senator Shelley:

During the absence of Doctor Fishbein, the editor of *The Journal of the American Medical Association,* your letter of May 2 has been referred to me for reply, concerning Assembly Bill 1475 to amend the Business and Professions Code for the purpose of imposing certain requirements on applicants for licenses to practice medicine in California who are graduates of foreign medical schools other than Canadian schools.

This bill requires such an applicant to submit documentary evidence, satisfactory to the Board of Medical Examiners, that (1) he has completed a resident course of professional instruction in an approved medical school or schools equivalent to that required for a physician and surgeon applicant; (2) he has had issued to him by such approved medical school, subsequent to the completion of the resident course, a medical diploma; (3) he has been admitted or licensed to practice medicine in the country wherein his professional instruction was obtained; (4) he has completed either the senior or fourth or final year in an approved medical school in the United States, or in lieu thereof documentary evidence that he has served at least one year in residence in a hospital located in the United States and approved by the board for training of interns; and (5) if the applicant is not a citizen of the United States, documentary evidence that the country in which he has been licensed to practice medicine will admit to practice therein citizens of the United States upon proof of prior admission to practice medicine in some state of the United States or "upon proof of matters similar to those required in this section for graduates of foreign medical schools."

In your letter you asked if the American Medical Association has taken any position either in approval or disapproval of this legislation. As directed toward the particular California bill, it has not. In 1936, however, the House of Delegates of the American Medical Association at its Kansas City meeting adopted the following resolution concerning graduates of medical schools of foreign countries:

WHEREAS, Through the initiation, support, and watchfulness of organized medicine, standards of medical education and medical practice have rapidly and continuously advanced; and

WHEREAS, There is a serious danger of this most satisfactory state of progress being undermined, and weakened by the registration to practice of graduates of medical schools of foreign countries; and

WHEREAS, There are at the present time more than 1,500 American students attending medical schools in foreign countries, many of them not having satisfactory credentials for admission to American medical schools; and

WHEREAS, There is in the files of the Council on Medical Education and Hospitals of the American Medical Association, and the Federation of State Medical Boards, evidence that many of the foreign medical schools do not consistently maintain and enforce the same high standards as are maintained in the medical schools of the United States; therefore, be it

Resolved, That each applicant for medical license in the United States, in order to adjust this inequality and to show a knowledge of acceptable medical practice, should be required before being admitted to a written examination before a properly constituted examining board to hold a license to practice in the country of his graduation and a certificate that he has completed a year's work as an intern in a hospital approved for internship training or should complete the fourth year in an American Class A medical college; and be it further

Resolved, That the House of Delegates of the American Medical Association approve the foregoing and that a copy be sent to the properly constituted officers of each examining board of the United States and to the Federation of State Medical Boards, with the request that they consider seriously urgent need for the adoption of such rules and/or legislation necessary to put the purposes of these resolutions into effect.

While this Association has not considered the pending California bill, the bill does obviously propose to put into effect legislatively the recommendations contained in the resolutions adopted by the House of Delegates in 1936.

Personally, I do not believe that this bill has been prompted by any desire to discriminate against the graduates of foreign medical schools. It represents an attempt to protect the people of the State against the ministrations of incompetent practitioners who have received their medical instruction under circumstances that make it impossible for the Board of Medical Examiners to appraise the quality of that instruction. With respect to medical schools conducted in the United States and in Canada, the Board of Medical Examiners has means by which it can determine if the instruction given in such schools is of a sufficiently high quality to assure that graduates are fundamentally trained in the healing art. With respect to medical schools conducted elsewhere, the Board has no such means and hence in order to preclude the licensure of those who are poorly equipped to treat the sick, legislation along the lines of the pending bill would seem to be necessary.

As you may know, during the last decade graduates of foreign medical schools have been emigrating to the United States in ever-increasing numbers. I take it that there is no disposition anywhere to throw any obstacles in the way of such of these graduates who are able to convince the licensing authorities that they are adequately qualified. It is for the purpose of enabling the Board of Medical Examiners in California to make sure that such of these graduates as desire to practice in California are competent that the pending bill under discussion has been sponsored.

535 North Dearborn Street.

Yours truly,
J. W. HOLLOWAY, JR.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

Concerning a Point in Medical Defense.*

"While I am very glad that this case did not come to trial, I was particularly interested in the charge upon which it was based, *i. e.*, that I had not been frank in revealing to a patient the diagnosis of carcinoma and that my concealment of this fact from the patient had resulted in damages to his fortune, which he tried to collect from me.

"My attorneys told me that this particular point had not been tried in law before and have warned me of the necessity of having any relatives who instruct not to tell the patient that he has cancer, on their responsibility—to have such parties sign a release in which they accept the moral and financial responsibility of such a deception."

* Excerpt from a personal letter received from a member of the California Medical Association.

"A health commissioner is a John the Baptist, who recognizes that his only mission is to prepare the way for a greater than himself."—Anon.

MEDICAL JURISPRUDENCE†

By Hartley F. Peart, Esq.
San Francisco

Status of a Physician's Accounts Receivable Under Personal Property Tax Statutes

Under the personal property tax statutes of the State of California, a levy is made upon "solvent credits" of the taxpayer. The exact meaning of "solvent credits," is the subject of this article. Clearly, "credits" include bills payable by patients. However, what does the word "solvent" mean?

Section 2153 of the Revenue and Taxation Code provides:

> A tax of one-tenth of one per cent is hereby levied on the *actual value* of *solvent credits* and any interest thereon. . . .

Since most physicians have at all times a number of outstanding accounts payable to them, many of which may never be paid, it is necessary to ascertain if a deduction may be properly made from the total amount of credits of a sum equal to the bills which will in all probability not be collectible. For many years this has been a somewhat moot question.

The California tax laws were revised in 1939, and a Revenue and Taxation Code was enacted. This code was intended to contain substantially all of the laws of the state relating to taxation. The enactment of the code, however, did not clarify the issue with which we are concerned, and, if anything, rendered the answer more obscure. Section 113 provides:

> "Solvent credits" means all credits except notes, bonds, and debentures. . . .

Section 112 provides:

> "Credits" means solvent debts owing to the assessee, and any interest thereon unsecured by a mortgage, trust deed, contract, or other obligation where land is pledged as security.

Thus it can be seen that these sections reduce the term "solvent credits" to a meaning not different from the word "credits" itself as generally accepted. Article XIII, Section 1 of the State Constitution provides:

> All property in the State, except as otherwise in this constitution provided, not exempt under the laws of the United States, shall be taxed in proportion to its *value*, to be ascertained as provided by law or as hereinafter provided. The word "property," as used in this article and section, is hereby declared to include moneys, credits, bonds, stocks, dues, franchises, and all other matters and things, real, personal, and mixed, capable of private ownership; . . .

Section 110 provides:

> "Value," "full cash value," or "cash value" means the amount at which property would be taken in payment of a just debt from a solvent debtor.

A comparison of Article XIII, Section 1 of the constitution with Section 110 of the code reveals an uncertainty as to what shall constitute the "actual value" of accounts receivable. No case has been found in this state bearing upon this question, and it is generally accepted that there has been no judicial interpretation of the term "actual value" in its relation to accounts receivable.

The San Francisco Assessor's office has ruled that the "actual value" of accounts receivable shall be the proportion of the accounts which are *probably collectible*. This same position has no doubt been taken by other assessors, since it seems to be the only logical interpretation of the law. It is this same question of interpreting the laws in relation to the meaning of the word "value" which causes the various assessors a great deal of consternation when they attempt to assess various types of property, and all are hoping that the courts will soon settle the matter.

Since it is the practice for an individual to make his own estimate of the value of his personal property, it would seem reasonable for him to base his estimate upon that percentage which past years have shown will most probably be received from his accounts receivable.

† Editor's Note.—This department of California and Western Medicine, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

Reserve Commissions Offered to Senior Medical Students.—"All senior medical students graduating from fully accredited medical schools in the United States this spring will be afforded the opportunity of being appointed first lieutenants in the Medical Corps Reserve of the Army," *The Journal of the American Medical Association* reports in its *Medical Preparedness Section*. "The students who did not pursue formal instruction in the Reserve Officers' Training Corps will be eligible for appointment in the Medical Corps Reserve on a par with those students who did have the advantage of such instruction.

"These appointments will be made by the War Department on the recommendation of the dean of each approved medical school and on his certification that the applicant will be granted the degree of doctor of medicine on a specified date. At those schools which require a hospital internship for such degree, appointment will be made on certified evidence of the prospective successful completion of the prescribed four-year course of medical instruction. Commissions and letters of appointment will be delivered on graduation. The newly commissioned Medical Reserve officer should then present his letter of appointment to his local Selective Service board for reclassification.

"No Medical Reserve officer is considered eligible for extended active duty until he shall have completed at least one year of postgraduate hospital internship. Therefore, members of this year's graduating class who are appointed in the Medical Corps Reserve, either through medical units of the R. O. T. C. or under the aforementioned procedure, will not be available for active duty until July, 1942. Deferment of such duty beyond that time will depend on the current requirement for medical officers.

"In view of the anticipated annual demand for approximately four thousand Reserve medical officers to replace those who have completed twelve months training and service, it is doubtful that such deferments will be possible.

"The War Department approved appointment of senior medical students on February 18, and appropriate instructions were directed to the commanding general of each corps area. The deans of the several approved medical schools will receive complete instructions, together with appropriate application blanks, in the near future from the commanding general of the corps area in which the institution is located."

Eponym

Henle's Loop.—This anatomic structure was described by Friedrich Gustav Jacob Henle (1809-1885), professor of anatomy at Göttingen in his *Handbuch der systematischen Anatomie des Menschen* (Vol. II, p. 303; Braunschweig, 1862). A portion of the translation follows:

"The narrow canaliculae are always found in the interstices between the larger ones, running parallel with them and showing no tendency whatever to join them. Instead, they terminate at various levels, the lowest immediately under the surface of the papillae in the bridges between the larger canals, and are blind in the sense that two neighboring canaliculae join together in a sharp loop. Because of this course, I have given them the name of loop-shaped canaliculae."—R. W. B., in *The New England Journal of Medicine*.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XIV, No. 7, July, 1916

From Some Editorial Notes:

Malpractice Defense.—As all our members know, the State Medical Society has been defending its members in suits brought for damages for alleged malpractice, subject to certain rules and regulations, since July 1, 1909. [This statement as of July, 1916.] Before referring to the recently approved extension of the work, it may be well to set forth here briefly the rules and regulations covering the operation of the present work.

1. The physician defendant must have been a member in good standing, dues fully paid, at the time of the alleged malpractice, and also at the time when the suit is filed against him.

2. Any member sued, or threatened with suit, must, within forty-eight hours, notify the Secretary of the State Society, forwarding any communications, summons and complaint, or correct copy thereof, with a full statement of the case.

3. If such member is also insured in an indemnity company, he must elect whether to have the company of this Society take charge of his defense; and he must be advised by the Secretary of the Society that if he does not immediately notify the insurance company, he violates his contract with the company and practically cancels his policy, in which event, if a judgment went against him, the company would not be compelled to pay it.

4. An action in the nature of a cross-complaint, brought against a member who has sued a patient to collect an account due within one year from the termination of the services, will not be defended by the Society, unless such member has, before suing his patient, applied to the Council of the State Society for, and received, permission to bring such suit.

5. The Society will not defend a member in an action originating in the treatment of some injury where an x-ray plate would have been of benefit and advantage in making a correct diagnosis, or in correctly treating the patient, and was not so taken, unless the member so sued can furnish the Council with a full and satisfactory explanation of why an x-ray plate was not made and kept by him.

All of these rules are comparatively simple and all of them have been approved by the House of Delegates of the State Society.

In any case where a member is being defended by an insurance company, and in which we feel that it will be desirable to have our own attorneys participate in such defense, we so participate. The Society makes sure that everything which should be done for the protection of its members has been and is being done.

* * *

Paying Judgments.—When the medical defense plan was adopted, the Society decided not to include the settlement of judgments which might go against members. As a result of this decision, quite a good many members, who felt that they might at some time or other have a judgment against them, have carried indemnity insurance with one or more insurance companies. Such a policy with an insurance company costs from $15 to $30 a year.

(Continued in Front Advertising Section, Page 7)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By Charles B. Pinkham, M. D.
Secretary-Treasurer

News

"The State Senate today defeated, 28 to 7, a bill by Senator John Harold Swan of Sacramento, proposing to set up a separate board for examination and licensing of naturopaths. Opponents charged that the bill was favored by chiropractors, among others, as a method of gaining broader authority for that profession, and contended such a move should be made in the form of amendments to the Chiropractic Act." (San Francisco *Examiner*, May 16, 1941.)

"Governor Olson today vetoed a bill by Assemblyman Roger Pfaff which would have provided that an alien physician or surgeon applying for a license to practice medicine in California be compelled to submit evidence showing that the nation which issued his license admits United States licensed physicians to practice. The measure, which was fought in the Assembly, contained a provision that its restrictions would not apply to persons registered as interns as of March 31, 1941. Declaring that few foreign nations admit United States licensed physicians to practice, the Governor characterized a ban on the services of refugee physicians as a 'needless waste of human knowledge', and said he understood there was a dearth of medical men in national defense programs." (San Francisco *News*, May 10, 1941.)

"The California Physicians' Service today extended its low-cost medical and hospital service by offering a new plan to employ groups throughout the state, the California Medical Association announced. The plan, available to groups of fifty or more employees, offers hospitalization for any illness, operation or accident, and also the doctor's services for all operations in or out of the hospital. The cost to the wage-earner for participation in the plan is $1.20 a month. For an additional $1.35 a month, he may secure full hospital services for his wife and children. The plan was expected to appeal to many low-income families." (San Francisco *News*, June 4, 1941.)

"A proposal to establish an organization in San Jose with members securing low-cost medical service under a prepayment plan was outlined to delegates of the Central Labor Council last Friday night by Dr. E. T. Anderson, local physician. Anderson is contacting key union labor organizations in an effort to secure support of the plan. . . . Doctor Anderson is a brother of Dewey Anderson, former Assemblyman of Santa Clara County and now a key member of the well-known Temporary National Economic Committee, whose report on national social and economic conditions is one of the recent highlights of the Roosevelt administration." (San Jose *Union-Gazette*, May 30, 1941.)

"Dr. Nathan S. Housman today won a thirty-day stay in execution of a superior court sentence of one to fourteen years in San Quentin for preparing and offering false evidence. The stay was granted by Judge John T. Nourse of the District Court of Appeal, pending the outcome of an appeal of the case to the United States Supreme Court." (San Francisco *Call-Bulletin*, June 2, 1941.)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

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* Trade Mark Reg. U. S. Pat. Off. Word "Vioform" identifies the product as iodochloroxyquinoline of Ciba's manufacture.
1 Craig, C. F.: Amebiasis and Amebic Dysentery (1934).
2 Zener, F. B., Am. Jl. Surg. 44:416 (1939).

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MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 26)

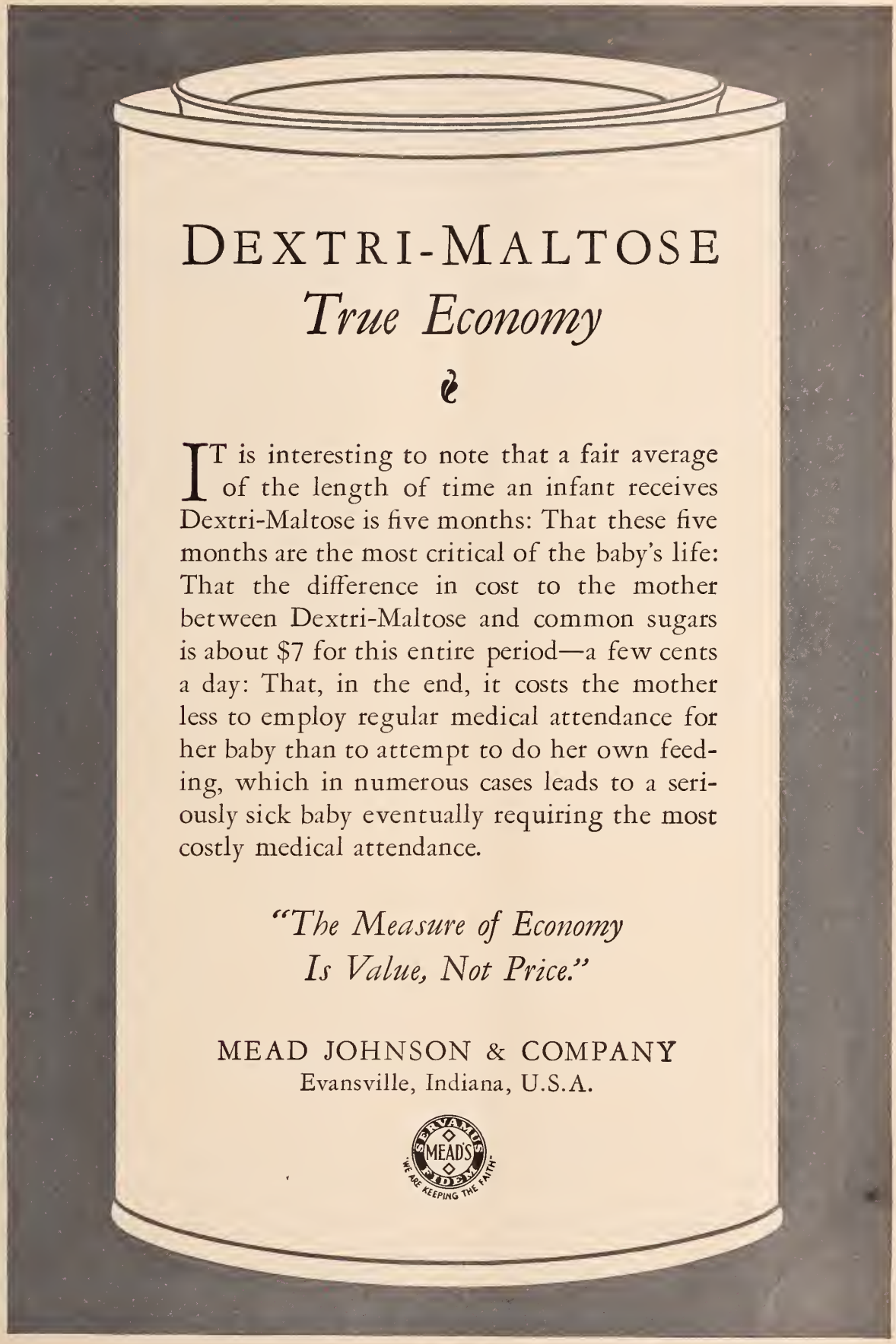
Social Insurance.—Herewith a brief report of a meeting of the Committee on Social Insurance of the Medical Society of the State of California, held in San Francisco May 20. Elsewhere in the *Journal* there will be found some additional matter relating to this most important subject, and a copy of the circular of information which was sent to all county society secretaries. A great deal of interest and enthusiasm on this subject seems to have been raised, and it is a most fortunate thing that such is the case. The statement of Doctor Lambert, chairman of a similar committee of the American Medical Association, to the effect that, in his judgment, this is the most momentous and important problem facing the medical profession of the United States, is undoubtedly true, and its truth is evidenced by a committee of the American Medical Association with an appropriation sufficient to permit it to do whatever is needed in the way of keeping the medical profession in touch with what is going on.

* * *

County Society Notices.—To all County Society Secretaries: Dear Doctor: Enclosed is some matter from the Committee on Health Insurance which is of the greatest importance to every physician. You should read it carefully and present the gist of it to your society, and at the same time urge them to follow carefully all that is published on this subject in the *State Journal* from month to month.

The State Society, at the Fresno meeting, authorized the Council to prepare a plan whereby such members as wished to might contribute to a fund for the purpose of paying

(Continued on Page 32)



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Is Value, Not Price."

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TWENTY-FIVE YEARS AGO

(Continued from Page 30)

judgments and the like; in other words, covering such members as fully as any insurance company could do. The full details of this plan and arrangement will appear in the July number of the *Journal*. Please urge your members to look for this and study it carefully when it comes out. Cordially yours, Philip Mills Jones, Secretary.

To County Societies:

Your attention is herewith called to the following facts:

1. The last legislature authorized, and the Governor has appointed, a Commission to Investigate and Report upon Systems of Social Insurance.

2. This Commission has undertaken an intensive study of sickness insurance, this seeming more practicable for the present than the study of insurance against old age, invalidity, unemployment, and death. . . .

6. . . . The State Society's Committee feels that, in the study of sickness insurance, it is important that the entire profession take an active part. The legislature will have met before this Committee will have been able to report to the Society at large.

7. It, therefore, and hereby requests the appointment of a Social Insurance Committee in every county medical society.

8. The State Committee will keep in touch with all county committees, and endeavor to place all available information at their disposal.

9. The work is important. Please appoint your committee immediately and report at once as to its personnel to the Secretary of the State Society, in the enclosed envelope. Yours truly, Rene Bine, chairman, Committee on Health Insurance. Address: 350 Post Street, San Francisco.

From an Original Article on "Second Thoughts About Salvarsan Therapy," by William E. Stevens, M. D., San Francisco.—As the supply of salvarsan and neosalvarsan has been temporarily discontinued, it seems appropriate at this time to consider some of the contraindications for their use and common errors in the technique of the various methods of administration. These preparations, of great value in the treatment of syphilis, contain large amounts of arsenic and are capable of producing some very disastrous and even fatal results when incorrectly employed. This important fact seems to have been lost sight of, for salvarsan has been carelessly, even recklessly, used by many reputable practitioners. . . .

From an Original Article on "Chronic Appendicitis Complicating Pulmonary Tuberculosis," by Jno. C. King, M. D., Banning.—All systematic writers upon pulmonary tuberculosis emphasize the frequency of gastric symptoms. Many claim that indigestion, in its various forms, is a necessary concomitant of the disease. The digestive organs are of utmost importance in all chronic diseases because they represent nutrition. In tubercular patients, nutrition is almost invariably faulty. They are poor eaters, whether through poverty or habit. Forced feeding and other similar methods have fallen into partial disuse because of their

(Continued on Page 34)

Clinical advantages of 'Propadrine' Hydrochloride in symptomatic control of hay fever and asthma

'Propadrine' Hydrochloride (phenylpropanol-amine hydrochloride) is a primary amine with similar pharmacological action and the same field of clinical application as ephedrine. The clinical characteristics of 'Propadrine' Hydrochloride in the symptomatic control of hay fever and asthma are manifested by:

1. **The comparative absence of side-effects such as insomnia, nervousness, excitation, and enuresis.**
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'Propadrine' Hydrochloride, because of its bronchodilator action, affords relief to many asthmatic patients in 3/8-grain doses every three hours. This may be increased to 3/4 grain every three hours in adults and in children over eight years of age without untoward effect.

Solution 'Propadrine' Hydrochloride is also of value in allergic rhinitis with associated edema of the nasal mucous membrane.

How Supplied

CAPSULES: 3/8 grain—bottles of 25, 100 and 500; 3/4 grain—bottles of 25, 100 and 500.

ELIXIR: Each fluidounce contains 2 grs. 'Propadrine' Hydrochloride. In pints and gallons.

SOLUTION (Aqueous): 1% (isotonic)—1-ounce and pint bottles; 3%—1-ounce and pint bottles.

NASAL JELLY: in 1/2-ounce tubes containing 0.66% 'Propadrine' Hydrochloride.

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The BACH CERVICAL CAP PESSARY provides an easy, non-injurious, efficient method of contraception which, with the BACH PESSALATOR (applicator), can be utilized by any qualified physician.

There are three sizes: regular, medium and large, but the "regular" size will usually fit the average normal cervix.

PRICE: BACH PESSARY and BACH PESSALATOR—$1.50 each. Samples, limited to 6, 60c for Pessary and 60c for Pessalator.

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For particulars address:

THE POTTENGER SANATORIUM AND CLINIC, Monrovia, California

TWENTY-FIVE YEARS AGO

(Continued from Page 32)

supposed injurious effect upon the digestive organs; and yet, from the standpoint of nutrition, they represent an important principle. . . .

From an Original Article on "A Statistical Study of Rabies in California," by J. C. Geiger, M. D., Assistant Director, Bureau of Communicable Disease of the California State Board of Health, Berkeley.—Since 1909, and until recently, rabies has been epidemic in California. Despite the dissemination of knowledge in regard to the control of the disease, rabies among animals in California steadily increased. The height of the epidemic has been reached and passed, and rabies may be considered under control except in Modoc and Lassen counties. This is partly due to the peculiar tendency of an epidemic of rabies to spend itself, the measures instituted for control, and the fact that the disease has become endemic in the more populous communities.

The advent of the disease in coyotes in Modoc and Lassen counties, which was accomplished through infection traveling from Oregon and Nevada, was made the basis of a remarkable campaign against these animals by the California State Board of Health. The financial loss in livestock alone in Modoc and Lassen counties from rabies places this disease in the forefront as the enemy of cattle and sheep men. Therefore, the prompt eradication of rabies is a necessity, both in city and rural communities, because of the serious element of human danger on the one hand, as shown by the large number of deaths from rabies in

(Continued on Page 36)

Pontocaine Hydrochloride IN

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FOR topical anesthetization of the mucous membranes of the nose and nasopharynx, a 2 per cent concentration of Pontocaine hydrochloride need not be exceeded. In many cases, a solution of lower strength (0.5 or 1 per cent) is adequate.

The procedures which can be carried out under surface anesthesia include cauterization or removal of turbinates, puncture and irrigation of the sinuses, removal of polypi, and painful examinations.

For endolaryngeal procedures, such as removal of polypi, puncture of cysts, cauterization of laryngeal tubercles, and biopsy, Pontocaine hydrochloride is applied with a dropper or spray in the same manner as cocaine.

HOW SUPPLIED: *For surface anesthesia in rhinolaryngology,* Pontocaine hydrochloride 2 per cent solution, in bottles of 1 oz. and 4 oz.

Also Useful in Ophthalmology

For surface anesthesia in ophthalmology, Pontocaine hydrochloride 0.5 per cent solution, in bottles of ½ oz. and 2 oz.

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TWENTY-FIVE YEARS AGO

(Continued from Page 34)

human beings in California, and from an economic standpoint on the other, as shown by the experience of Modoc and Lassen counties. . . .

From an Original Article on "Danger of Baths in Patients Suffering from Arteriosclerosis," by William Watter Kerr, M. D., San Francisco.—As the time of year is at hand when people are arranging to leave town for the summer months, the following cases may be of interest to those physicians who are liable to be consulted by their patients regarding the propriety of visiting one or other of the many springs which abound in California. It not infrequently happens that too little attention is given to the fitness of individual cases to hydrotherapy, and consequently harm is done to the patient and also to the reputation of the particular spa which he chanced to select, so that others who would receive benefit are deterred by their friend's misfortune from availing themselves of the treatment. The popular idea that the surroundings at the various resorts are responsible for all improvement, and that although the baths may fail to relieve, yet they never will do any harm, is extremely unfortunate. At least two things should be impressed upon those seeking advice: (1) That hydrotherapy is not adapted to all cases, and (2) that the temperature and method of administration are of much greater importance than any salts contained in the water. . . .

(Continued on Page 38)

INDIVIDUALIZED FORMULAS FOR THE NEWBORN

NORMAL INFANTS

Whole milk .....10 ozs.
Water, boiled .....10 ozs.
Karo syrup ..... 2 tbs.

Evaporated milk ..... 6 ozs.
Water, boiled .....12 ozs.
Karo syrup ..... 2 tbs.

Powdered milk ..... 5 tbs.
Water, boiled .....20 ozs.
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Evaporated goat's milk.. 6 ozs.
Water, boiled .....12 ozs.
Karo syrup ..... 2 tbs.

Hypoallergic milk .....10 ozs.
Water, boiled .....10 ozs.
Karo syrup ..... 2 tbs.

Sobee ..... 8 tbs.
Water, boiled .....18 ozs.
Karo syrup ..... 2 tbs.

NEUROPATHIC INFANTS

Evaporated milk ..... 7 ozs.
Water, boiled .....13 ozs.
Barley flour..... 3 tbs.
Karo syrup ..... 1 tbs.
(cooked ten minutes until thick)

Whole milk.....12 ozs.
Water, boiled..... 6 ozs.
25% Lactic acid..... 2 tsp.
Karo syrup ..... 2 tbs.

2% Lactic-acid milk ....18 ozs.
Karo syrup..... 2 tbs.

"Infants Thrive on Karo Formulas"

"Newborns tolerate a simple formula consisting of 10 ounces of boiled fresh cow's milk, 8 ounces of sterile water and 1 ounce of mixed sugar. Added carbohydrate in the form of corn syrup is usually better tolerated than the simple sugars, lactose or sucrose. At first, about one ounce of the formula will be taken at a time although the infant is allowed all he will take of the three ounces and the remainder discarded. The allergic newborn may be given evaporated cow's-milk or goat's-milk formulas; the hypertonic newborn thick feeding; the hypotonic newborn, evaporated or lactic-acid milk formulas."

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Sucrose	4%		
Invert Sugar	3%		
Minerals	0.6%	1 teaspoon	20 cals.
Moisture	25%	1 tablespoon	60 cals.

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TWENTY-FIVE YEARS AGO

(Continued from Page 36)

Society Reports:

Placer County.—The Placer County Medical Society held its regular meeting in Auburn, Saturday evening, March 25. Through the courtesy of the Trustees of the Placer Union High School, the Assembly Hall of that building was used as a place of meeting. . . .

. . . Dr. James G. Cumming, Director of the Bureau of Communicable Diseases of the State Board of Health, read a paper, entitled "The Protection of Public Water Supplies, with Special Reference to Dysentery and Typhoid Fever." Professor W. B. Hearms of the University of California, who has charge of the special work to be done by the State Board of Health in its campaign against malaria, gave an address, illustrated by lantern slides, on "Practical Aspects of Malaria Control."

These papers were discussed by members of the Society and visitors.

It is expected that the next meeting will be held in Roseville.

Robert A. Peers, M. D., Secretary.

Social Insurance.—The question of sickness insurance in this state [California] opens up such a large field for study as to make it imperative for us all to coöperate, in so far as possible, in an intensive investigation of the problems involved. It is very important that your committee, representing, as it does, the medical profession of the state, should post itself as to all phases of the study, and not concern itself alone with the attitude of the profession toward any scheme for sickness insurance.

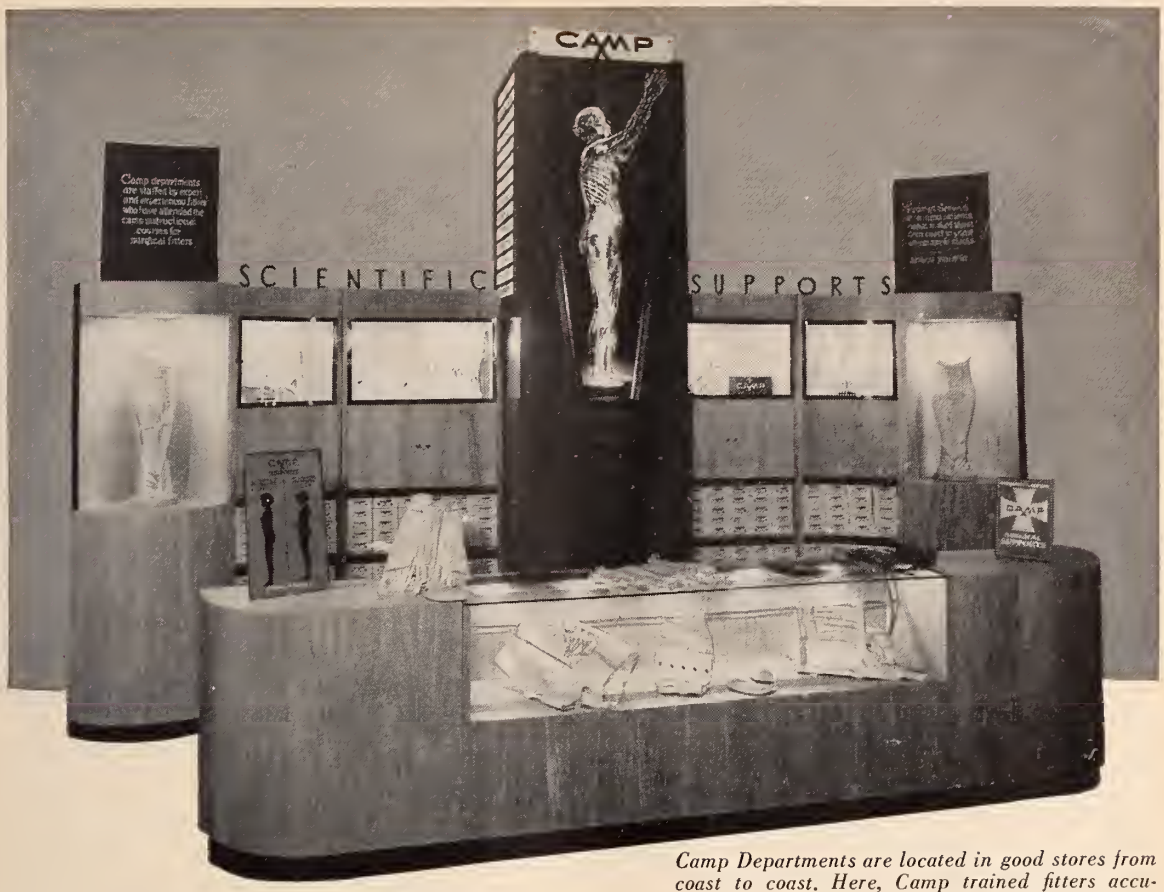
It is with this view in mind that I shall attempt to furnish your committee, from time to time, with what information we are able to gather here in San Francisco. A few months ago a group of us, interested in social insurance, at the suggestion of a member of the Social Insurance Commission of the State of California, decided to hold weekly evening meetings so that we could take up and discuss these matters.

The Commonwealth Club of California has, likewise, organized a study committee. It meets every Friday afternoon from 4 to 6 p. m. On it we find employers, employees, staunch representatives of labor, insurance men, statisticians, physicians. They have mapped out a rather ambitious program for study. . . .

New Sections.—Acting upon the request of the House of Delegates, the Council has created a section on Obstetrics and Gynecology, with Dr. E. N. Ewer as chairman, to serve until the annual meeting of 1917, and a section on Neurology and Psychiatry, with Dr. A. W. Hoisholt, chairman, and Dr. J. Ross Moore, secretary. Doctor Ewer will appoint the temporary secretary of the Section on Obstetrics upon his return from the East.

Medicine and Dentistry.—First University Dental School in New York for Columbia. Realizing the importance of the teeth and mouth infections to systemic disease, the

(Continued on Page 40)



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This Institution supplies, among other advantages:

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TWENTY-FIVE YEARS AGO

(Continued from Page 38)

Faculty of the College of Physicians and Surgeons have unanimously voted in favor of the establishment of a dental department, to be connected with the medical school. A committee of prominent dentists of the city have presented plans to the Medical Faculty which have been approved.

The school of dentistry will be closely associated with the medical school, and the admission requirements will be the same as the medical. The course will be four years, the first two years the same as those in medicine, thus giving the dental student a thorough knowledge of the fundamental sciences necessary to the practice of a specialty of medicine. At the end of the second year the dental student will give all his time to the study of dental subjects, namely, operative dentistry, prosthetic dentistry, oral surgery and oral pathology, orthodontia, etc., and the more technical part of the work required for the well-trained dental surgeon. This new school will be the first university dental school in New York City and the second in the state. It will give the first four-year course of dentistry ever given in the Empire State.

Two Cases of Skin Rash from Dextrin Used as Adhesive on Tax Stamps.—Two cases of a skin rash due to the dextrin used as an adhesive on tax stamps are reported by Doctors J. D. Walters and E. C. Stern, Cleveland, in *The Journal of the American Medical Association.*

The two patients affixed the stamps by hand to packaged goods. They both recovered quickly when long-sleeved garments were used at work, when the containers of the water for moistening the stamps were washed frequently, and when the hands and cloths used to wipe away excess moisture from the stamped goods were rinsed frequently in running water.

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(1) 1941. Canner 92, No. 12, Pt. 2, pages 78-81. 1936 Canner 82, No. 11, Pt. 2, pages 104-105.

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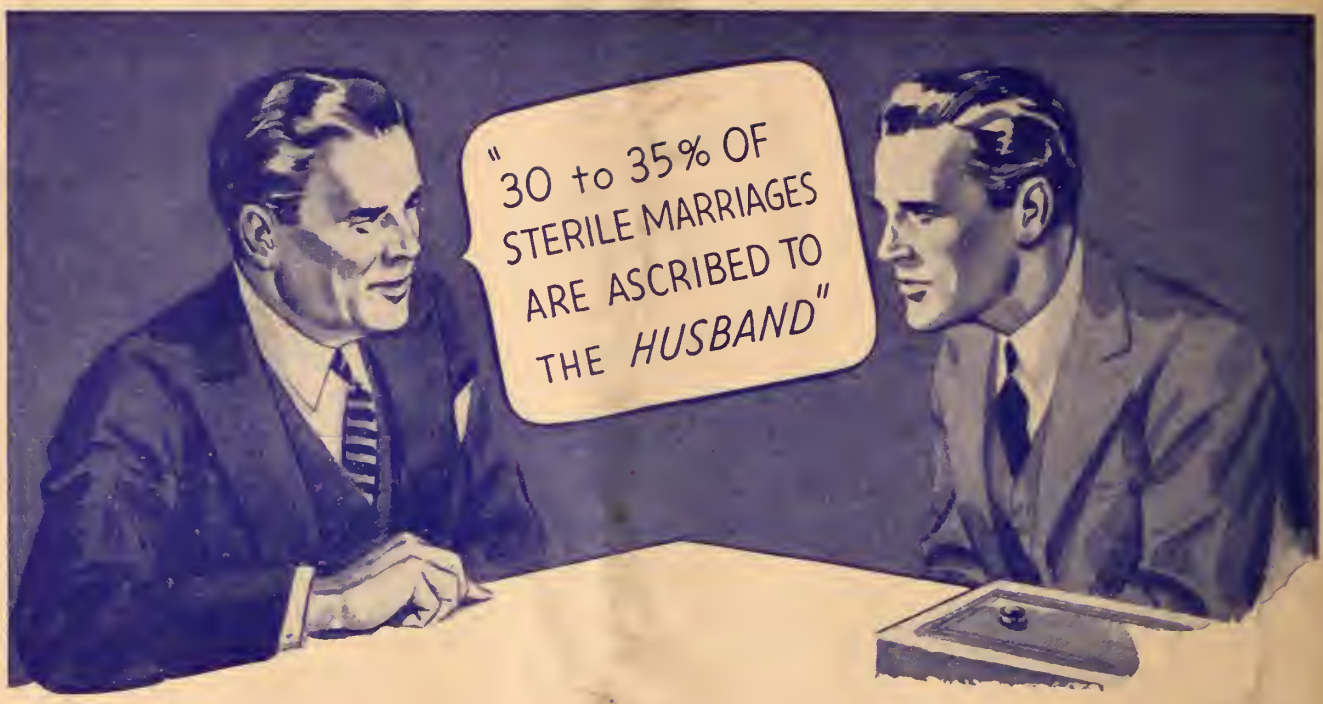

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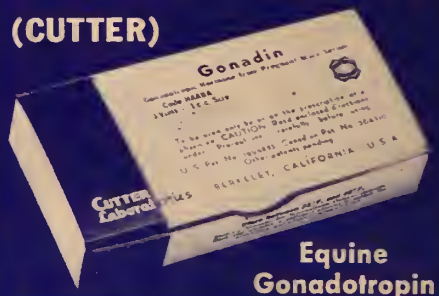

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NUMBER 2

AUGUST · 1941

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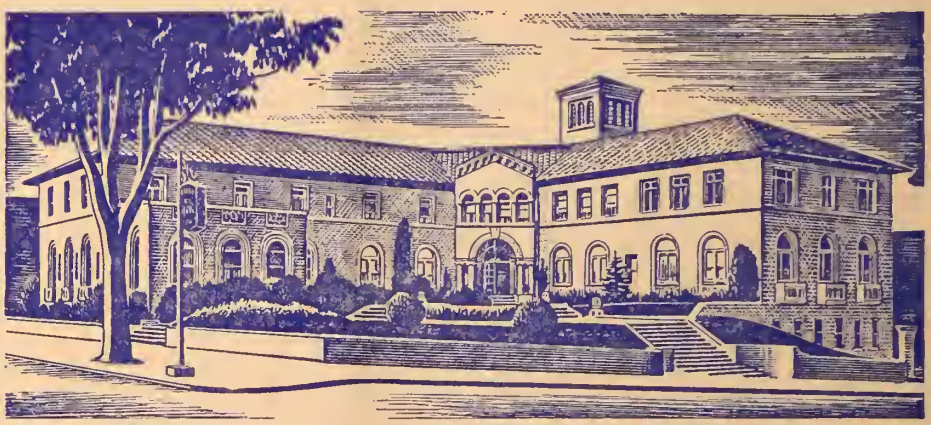

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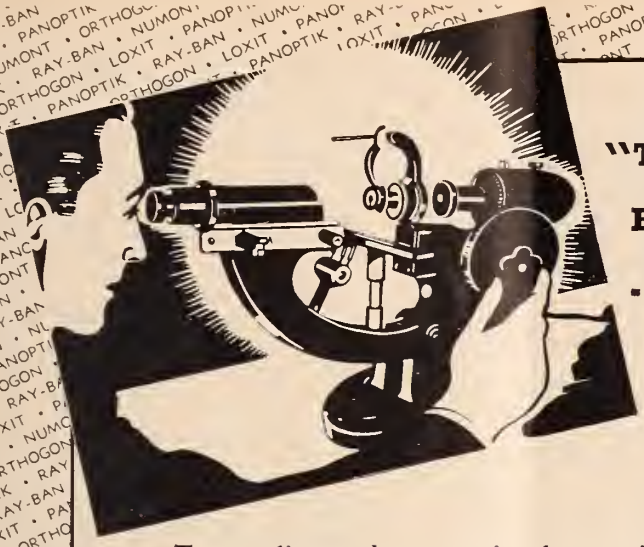

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Secretary, J. E. Young, 405 Rowell Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society

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Secretary, Joseph S. Woolford, 350 E Street, Eureka.
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Imperial County Medical Society

President, William A. Clarke, 132 Fifth Street, Holtville.
Secretary, Claude F. Peters, 722 Main Street, El Centro.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

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President, H. W. Crook, 106 S. Main, Bishop.
Secretary, George Shultz, 124 N. Main, Lone Pine.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society

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Secretary, Sophie M. Loven, 458 Haberfelde Building, Bakersfield.
Meeting, *Third Thursday, 8:00 p. m.*

Kings County Medical Society

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Secretary, Arthur Zeismer, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

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Secretary, Bernard S. Holm, Quincy.
Meeting, *On Call.*

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1925 Wilshire Boulevard, Los Angeles

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Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
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Secretary, Carl W. Clark, 1010 B Street, San Rafael.
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Napa County Medical Society

President, R. C. Burkett, 1130 First Street, Napa.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association

President, Lawrence C. Cameron, 218 South Main Street, Santa Ana.
Secretary, Milo K. Tedstrom, 1626 Bush Street, Santa Ana.
Meeting, *First Tuesday, 8:00 p. m. Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society

President, Lucas W. Empey, Roseville.
Secretary, Robert A. Peers, Colfax.
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Secretary, Hobart M. Kelly, 3616 Main Street, Riverside.
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President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society

President, Eugene H. Hull, San Bernardino.
Secretary, A. E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital*

San Diego County Medical Society
1410 Medico-Dental Building, 233 A Street, San Diego

President, Frank A. St. Sure, 4067 Van Dyke Avenue, San Diego.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
2180 Washington Street, San Francisco

President, Harold A. Fletcher, 490 Post Street, San Francisco.
Secretary, L. Henry Garland, 2180 Washington Street, San Francisco
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society

President, Raymond Leroy Owens, 28 Cory Building, Lodi.
Secretary, George H. Rohrbacher, 1003 Medico-Dental Building, Stockton
Acting Secretary, C. A. Broaddus, 242 North Sutter Street, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton*

San Luis Obispo County Medical Society

President, Horace Hagan, 1215 Chorro Street, San Luis Obispo.
Secretary, E. M. Bingham, County Health Department, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society

President, H. H. Whitney, 1204 Burlingame Avenue, Burlingame.
Secretary, Thomas Farthing, 23 Second Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society

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Meeting, *Second Monday, Cottage Hospital.*

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Meeting, *Third Monday, 7:00 p. m., Sainte Claire Hotel, San Jose.*

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Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meeting, *First Tuesday of each month (except June, July and August), 7:30 p. m., Club Rio del Mar, Aptos.*

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Meeting, *Second Monday.*

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Secretary, J. F. Thurlow, 576 B Street, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society

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Secretary, A. E. Ghilotti, 1024 J Street, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

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Meeting, *At Call of President.*

Tulare County Medical Society

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Secretary, Forrest G. Powell, 222 W. Willow Street, Visalia.
Meeting, *Sunday Evening once a month.*

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Secretary, Robert K. Harker, 132 Fourth Street, Oxnard.
Meeting, *Second Tuesday, Ventura County Country Club.*

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Meeting, *First Wednesday.*

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1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," Am. J. Syph., Gon. & Ven. Dis., 23, 201 (March), 1939.

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BOOK REVIEWS

Principles of Psychiatric Nursing. By Madelene Elliott Ingram, R. N., with a foreword by Ross McC. Chapman, M. D. W. B. Saunders Company, 1940.

I very much like this inclusive and practical book on psychiatric nursing, and recommend it as a textbook for use by teachers and student nurses, whether or not they propose to specialize in psychiatric nursing. The following topics, for example, are self-descriptive, but I may add that they are well-formulated and interesting: A Survey of the Nurse as an Individual. Factors Essential in Establishing Satisfactory Rapport. Habit Formation and the Personal Hygiene of the Patient. Safeguarding the Patient's Personal Property. Feeding Problems. Suicide. Escape. Hazards. Accident. Admisson. Transfer. Discharge. Management of Active Patients. Group Management. Occupation and Industry as Therapy. Hydrotherapy. Behavior. Organic Reaction Types. Functional Reaction Types. Miniature Case Studies. Specific Psychiatric Treatments, e. g., shock therapy. It is satisfying to have good advice on Traveling With Patients. I think the student nurse, (and, for that matter, the medical student), should gain useful concepts of modern psychiatry from the study of this book of 428 pp. At the end of each chapter appear a Summary Outline, Questions, and a fairly comprehensive Bibliography. G. M.

Manson's Tropical Diseases. A Manual of the Diseases of Warm Climates. Edited by Philip H. Manson-Bahr, C. M. G., D. S. O., M. A., M. D., D. T. M., and H. Cantab, F. R. C. P., Lond., Senior Physician to the Hospital for Tropical Diseases, London, the Albert Dock Hospital and the Tilbury Hospital; Consulting Physician to the Colonial Office and Crown Agents for the Colonies; Consultant in Tropical Diseases to the Royal Air Force, etc. Eleventh Edition, Revised. Cloth, Pp. 1,083,

(Continued on Page 9)

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BOOK REVIEWS

(Continued from Page 7)

with 18 color plates, 15 half-tone plates, 364 figures in the text, 6 maps, and 28 charts. A William Wood Book. Baltimore: The Williams & Wilkins Company, 1940.

It is indeed a pleasure to review the latest edition of Manson-Bahr's "Tropical Diseases." For one who studied the older ninth edition under Dr. Manson-Bahr in 1931-32, and again in 1935, it is interesting to see the newer edition, and to refresh one's memory on some of the tropical diseases that I so frequently encountered during my six years of practice in Nigeria, British West Africa.

The book opens with two chapters on life and conditions in the tropics, and discusses the qualifications and preparations necessary for anyone who intends to practice in those regions. However, it is not my intention to review the book on the basis of its usefulness in the tropics, but rather to emphasize its applicability to both general practice and surgery in the more temperate climate of California. After the first two chapters, the book is divided into ten main sections and an appendix. The first section—dealing with *Fevers*—comprises the main part of the book, and is further divided into six sections according to the different causes of fevers: Blood Protozoa; Blood Spirochetes and Spirilla; Bartonella and Rickettsia bodies; Bacteria, Viruses; and Atmospheric Causes. Then follow sections on Vitamin Deficiency Diseases; Abdominal Diseases; Infective Granulomatous Diseases; Diseases of the Central Nervous System; Tropical Venereal Diseases; Tropical Skin Diseases; Local Diseases; Animal Parasites; and Diseases due to poisons, etc. The appendix deals with medical zoölogy and laboratory methods. Throughout, the book is copiously illustrated with color plates, half-tone plates and figures in the text. There are also a number of charts and graphs, and some very interesting maps, showing the distribution of the different diseases.

There are a number of tropical diseases that we see more or less frequently in the United States, and particularly in California, first port of call from the Orient and many of the tropical countries. Consequently, it behooves the practicing physician to be somewhat familiar with these diseases. I know whereof I speak, because, after being in

(Continued on Next Page)

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BOOK REVIEWS

(Continued from Preceding Page)

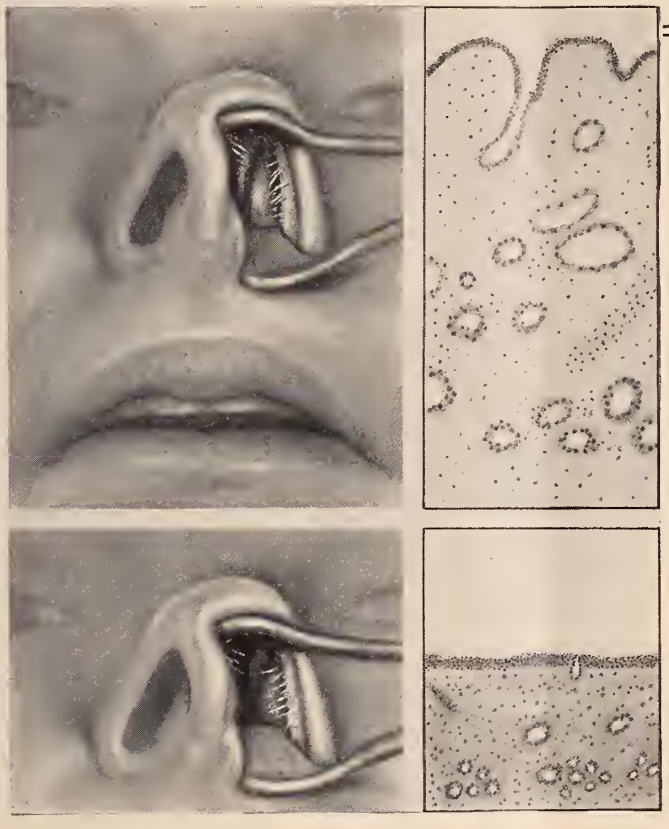
Nigeria for three years and practicing, like a man in a fog, with tropical diseases about which I had no practical knowledge, it was a revelation, on my first leave, to study at the London School of Tropical Medicine and Hygiene. I discovered, to my embarrassment, that I had operated on a man with a case of granuloma of the bladder, caused by Bilharzia or Schistosomiasis, when medical treatment with Tartar Emetic would have cured him. I had already found the Bilharzia ova in his urine, and had treated him with Tartar Emetic before surgery. After the operation, at which I had diagnosed cancer of the bladder, medical treatment was stopped. That, of course, occurred in the tropics, but during the five years that I have been practicing in San Diego—a Navy port and border city—I have seen one or more cases of the following diseases: Lymphogranuloma Inguinale; Amoebic Dysentery, both acute and chronic; Malaria; Undulant Fever; Leprosy; and both types of Bacillary Dysentery. All types of vitamin-deficiency diseases, such as Pellagra, Scurvy, and Beriberi are seen here, as are the tropical ringworm infections or yeast infections of the axilla, groin, vagina and penis. This is just a partial list, as it is only those that I remember off-hand. Then there are the other tropical diseases that we know occur here, although they have not come under my care. Some of these are: Rat-bite fever; the Mexican variety of Typhus; Mycetoma; and the plague in California rodents that is sometimes transmitted to humans.

All these, and probably others, are found here, but we do not see them often enough to remember their pathology, symptoms and treatment, and so must laboriously gather the required information from various sources, and trust that they are reliable. Such material is to be found in the eleventh edition which we now have in the San Diego Medical Library. It will pay us to read it more often.

The advantage of this work, edited by Doctor Manson-Bahr, is that the data are authentic from both a theoretical and practical standpoint. The author-editor has looked up the literature to get the facts straight, and he has practiced in several widely separated parts of the tropics. He was on some small islands in the southern Pacific for some time before World War I, and during the war he was with

(Continued on Page 14)

PATHOLOGY OF THE UPPER RESPIRATORY TRACT



(*Above*) Allergic Rhinitis
(*Below*) Five Minutes after application of Neo-Synephrin Hydrochloride

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In allergic rhinitis, relief from nasal congestion is the thing the patient urgently demands—the single criterion by which he evaluates treatment.

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Food Poisoning.—Why are more food-poisoning cases reported by laymen than by physicians?

Why are the more reputable restaurants, hotel dining rooms, and markets more often alleged to have served or sold the suspected food than the so-called beanery or the roadside stand?

Why does the victim often become violently ill and "almost die" immediately upon discovering a fly, spider, or match folder in the food or drink he is ingesting, and consult his attorney instead of his physician regarding his gastro-enteritis?

Although the incubation period for different forms of food infection varies a great deal, depending on the causative organism, why is it the victim is prone to incriminate one particular food purchased from one particular establishment?

Food poisoning (due to living bacteria or bacterial toxins) is reportable in California, and is listed as such on the Communicable Disease Report cards furnished to all physicians.

The Health Departments cannot examine food samples for infective organisms unless the original suspected food is available for analysis. Vomitus and early stool specimens are also of value. In any outbreak early reporting expedites matters in assisting the health authorities to obtain specimens and to remove an infectious food from the market.

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BOOK REVIEWS

(Continued from Page 10)

Allenby in Palestine and Mesopotamia. Since then, while teaching in London and during his travels, he has worked and visited in other tropical regions. In addition, he is in constant touch with men from all over the tropical medical world. Less than two years ago he visited his friend, Doctor Abbott, here in San Diego, and those of us who heard him enjoyed the experience immeasurably, and realized that they were listening to a real "Professor."

J. C. A., D. T. M. & H., San Diego.

BOOKS RECEIVED

Effective Living. By C. E. Turner, A. M., Sc. D., Dr. P. H. Professor of Biology and Public Health, Massachusetts Institute of Technology; Formerly Associate Professor of Hygiene, Tufts Medical and Dental Schools; Formerly Director of Health Education Studies, Malden, Massachusetts; Chairman, Health Section, World Federation of Education Associations, and Elizabeth McHose, B. S., M. A., Director of Physical Education for Girls and Chairman of the Health Council, Senior High School, Reading, Pennsylvania. Cloth. Price $1.90. Pp. 432, with 164 illustrations. St. Louis: The C. V. Mosby Company, 1941.

Orbital Tumors. Results Following the Transcranial Operative Attack. By Walter E. Dandy, Adjunct Professor, Neurological Surgery, Johns Hopkins University. Cloth. Price $5. Pp. 168, with 100 illustrations. New York: Oskar Piest, 1941.

X-ray Therapy of Chronic Arthritis. (Including the x-ray Diagnosis of the Disease). Preliminary report based on 100 patients treated at Quincy, Illinois. By Karl Goldhamer, M. D., Associate Roentgenologist, St. Mary's Hospital and Quincy X-ray and Radium Laboratories; Formerly Roentgenologist, University of Vienna, Honorary Member, Mississippi Valley Medical Society, etc. With a Foreword

(Continued on Page 16)

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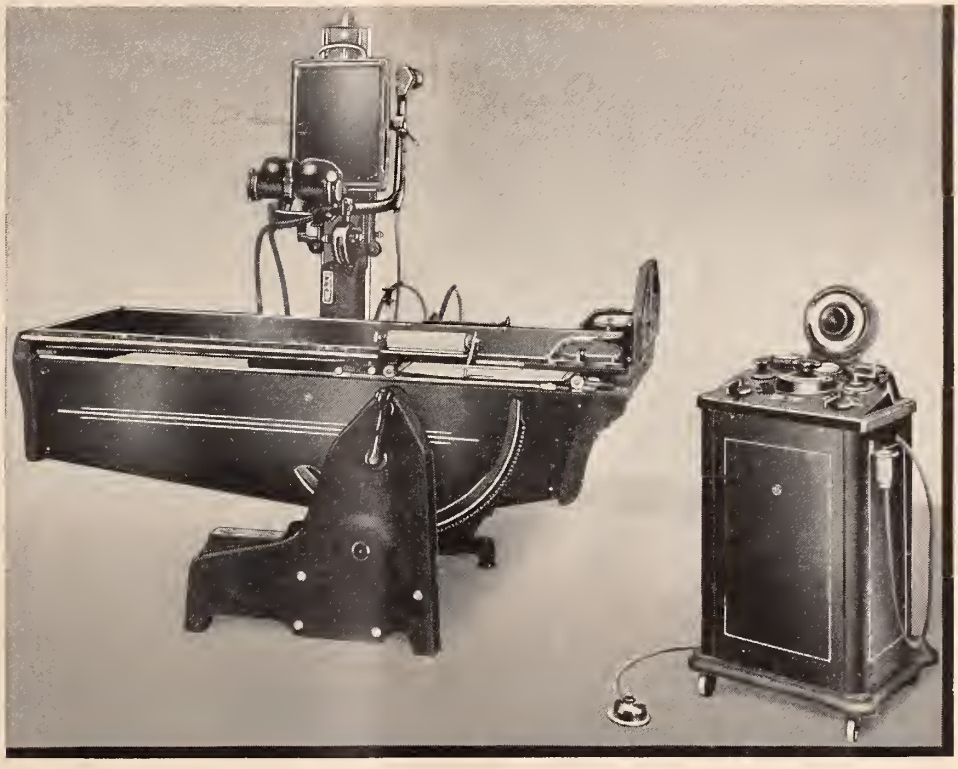

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BOOKS RECEIVED

(Continued from Page 14)

by Harold Swanberg, B. S., M. D., F. A. C. P., Editor, Mississippi Valley Medical Journal and the Radiologic Review; Roentgenologist, St. Mary's Hospital and Blessing Hospital; Director, Quincy X-ray and Radium Laboratories; Past President, Illinois Radiological Society, etc. Cloth. Price $2. Pp. 131, with 24 original illustrations by the author, two roentgenograms, and four tables. Quincy, Illinois: Radiologic Review Publishing Co., 1941.

Training and Efficiency. By E. Jokl, E. H. Cluver, C. Goedvolk, and T. W. De Jongh. Cloth. Pp. 188. Johannesburg: The South African Institute for Medical Research, 1941.

Electrocardiography. Including an Atlas of Electrocardiograms. By Louis N. Katz, A. B., M. D., Director of Cardiovascular Research, Michael Reese Hospital, Chicago, Illinois; Assistant Professor of Physiology, University of Chicago, Chicago, Illinois. Illustrated with 402 Engravings, including 806 Electrocardiograms. Cloth. Pp. 580. Price $10. Philadelphia: Lea & Febiger, 1941.

Exercises in Electrocardiographic Interpretation. By Louis N. Katz, A. B., M. D., Director of Cardiovascular Research, Michael Reese Hospital, Chicago, Illinois; Assistant Professor of Physiology, University of Chicago, Chicago, Illinois. Illustrated with 128 engravings containing 189 electrocardiograms. Cloth. Pp. 222. Price $5. Philadelphia: Lea & Febiger, 1941.

Infantile Paralysis. A Symposium Delivered at Vanderbilt University, April, 1941. Cloth. Pp. 239. New York City: The National Foundation for Infantile Paralysis, Inc., 1941.

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TWENTY-FIVE YEARS AGO

(Continued from Text Page 112)

of very large numbers of persons, expressing emphatically their idea that this country should not close its eyes to the possibility of future trouble. And this is wise.

There are innumerable bromidic remarks to support this point of view, as for instance:

In time of peace prepare for war.
God helps the country with the heaviest guns.
Heaven helps the man who helps himself.
Pray to God, and keep your powder dry!

From these few quotations from the dim and distant past, it becomes evident that the idea of preparedness is not altogether new.

* * *

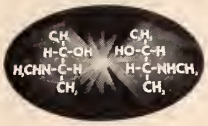
Fees Under the Industrial Accident Law.—A letter has been received from a distinguished member of the Society in Southern California, asking the JOURNAL to publish some facts in regard to the Industrial Accident Law, and the relation of the physician to it, and its provisions in the matter of fees. Many inquiries come in from time to time on different points directly connected with this, and therefore the following facts are set forth for your information and guidance:

The law makes it the duty of the employer to furnish medical and surgical attention to an injured employee, and therefore it further permits the employer to hire any physician or surgeon he chooses. The injured employee has nothing whatever to say in regard to what physician shall attend him. If the employer has transferred his personal risk to another by taking out insurance, the insurance company is then substituted for the employer in the matter of providing medical and surgical attention. In other words,

(Continued on Page 20)

RACĔPHEDRINE

in the Hay Fever Season



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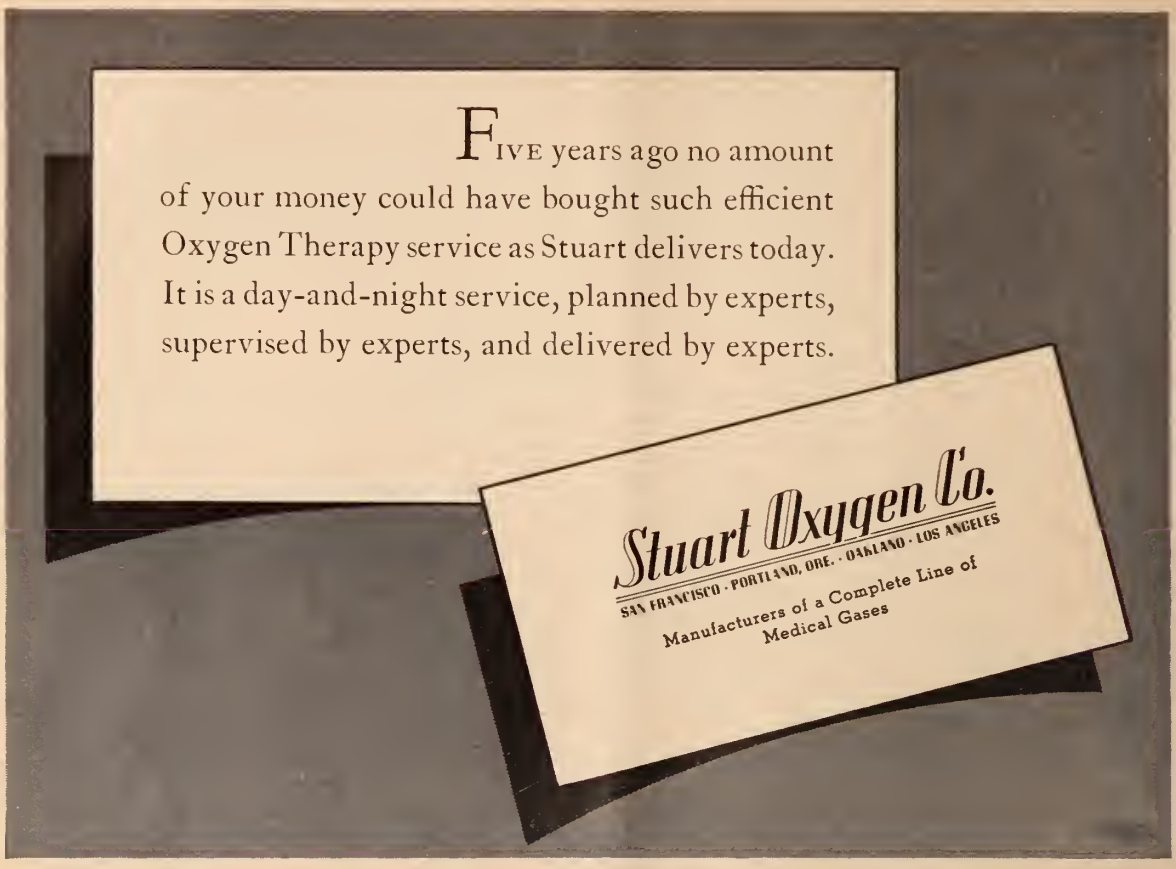

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TWENTY-FIVE YEARS AGO

(Continued from Page 18)

the insurance company says what doctor shall treat the injured employee. If an employee is injured and goes to some physician of his own volition and choosing, the employer, or the insurance company, cannot be compelled to pay that physician for anything more than the emergency treatment required by the necessities of the case. In every instance where an injured employee goes to you for professional services, you should find out from him immediately the name of his employer, and notify such employer, and also find out from the employer whether he is insured, and if so notify the insurance company and receive their authorization to treat the patient. Quite a number of complaints have come in that members, after having treated injured persons for a longer or shorter period, have been notified by the insurance company that, as the treatment was unauthorized, the company would not be responsible for the bill.

The Industrial Accident Commission has a limited jurisdiction over matters of dispute arising in connection with fees, but its jurisdiction does not in any degree extend to any case where the parties involved have not complied with the law. If you do not notify the employer or the insurance company, and get the consent of such employer or such company, you have not complied with the law, and you do not come within the jurisdiction of the Commission. . . .

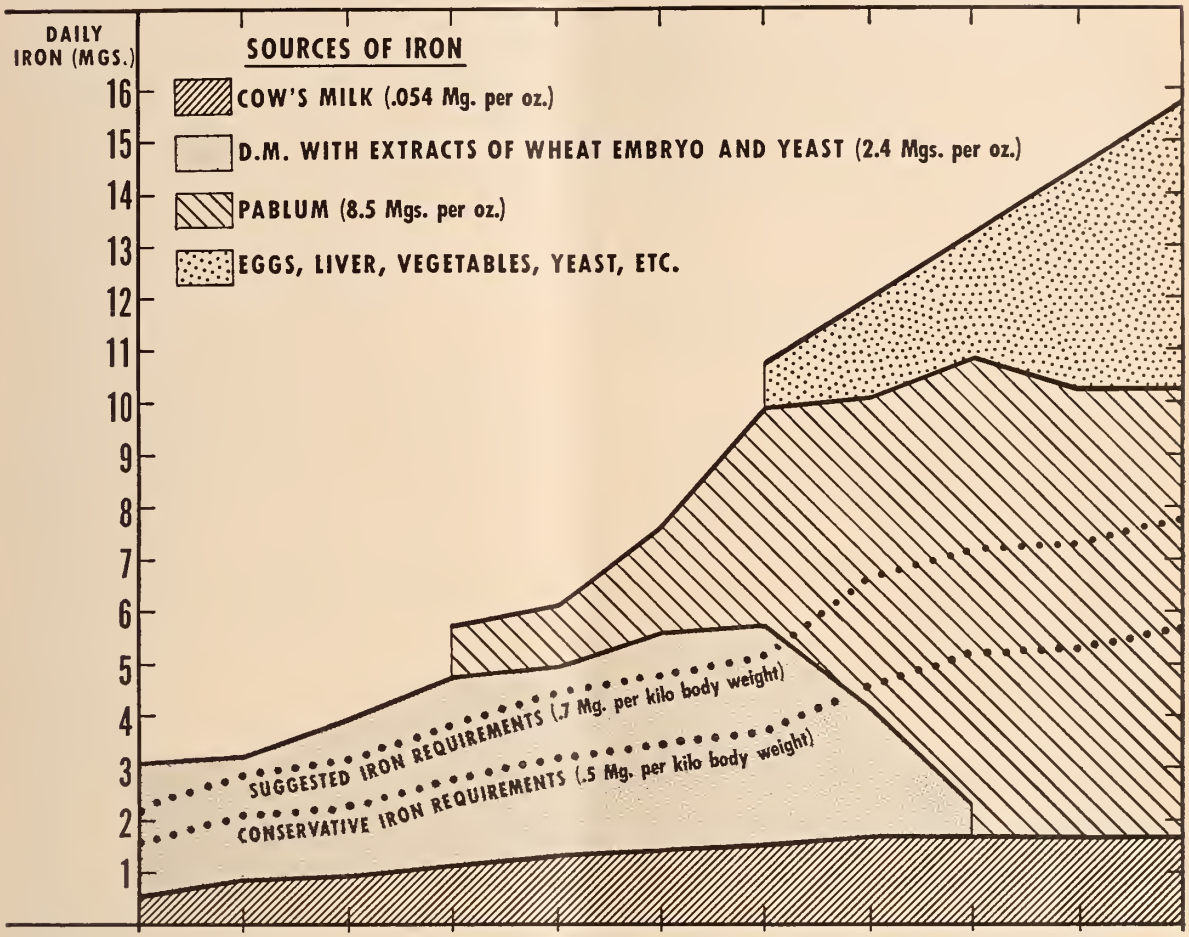
* * *

Infantile Paralysis.—The following item on the subject of poliomyelitis is issued by the State Board of Health, and is without apology given in connection with this editorial note. Elsewhere in the JOURNAL will be found an outline of an article published by the *Journal of the American Medical Association* on the same subject.

(Continued on Page 22)

IRON REQUIREMENTS

DURING THE FIRST TWO YEARS



AGE, Mos.	1/4	1	2	3	4	5	6	9	12	18	24
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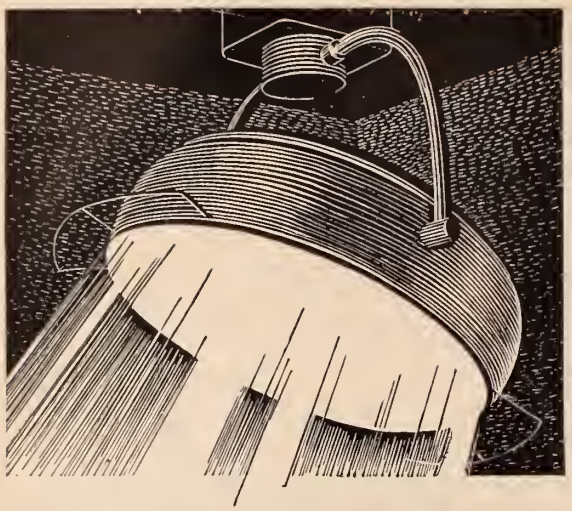
During fetal life the infant accumulates iron in its body. After birth, this supply is rapidly depleted, the hemoglobin frequently dropping to 50% by the third month, especially in prematures. Neither breast milk nor cow's milk is capable of offsetting this loss, as they are deficient in iron. An infant requires one-half milligram of iron per kilogram of body weight. This chart shows that when the carbohydrate and cereal supplements contain iron, a sizeable margin of safety can be maintained, not only during the important first six months, but throughout the first two years of life.

The excess iron thus supplied over iron requirements averages close to 75%, and is needed because some iron is unutilized — a large amount in certain cases. In rapidly growing, or poorly nourished infants, and in the presence of infection, the need for iron may be greater than the chart shows: in some cases, periodic hemoglobin determinations may show the need for iron therapy.

MEAD JOHNSON & COMPANY, Evansville, Ind., U.S.A.



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TWENTY-FIVE YEARS AGO

(Continued from Page 20)

Every effort to prevent the introduction of infantile paralysis into California is being exerted by the California State Board of Health. In order to learn if any cases or contacts are being brought into the State from the East, where the disease is now epidemic, inspectors of all transcontinental passenger trains have been stationed at points along the border lines where the railroads enter California. Without the coöperation of citizens, however, this procedure is of small importance. . . .

From an Original Article on "Congenital Pyloric Stenosis," by Alanson Weeks, M. D., San Francisco.—He who would treat a case of true so-called congenital pyloric stenosis medically should first be made to cut the tumor found in such a condition with a fairly sharp scalpel. The hypertrophy of the tissue found at the pylorus in these babies is so thick, and so dense, that relaxation with other than mechanical means should at last be believed to be out of the question.

The idea which should really be impressed upon all of us who treat babies is to make a correct diagnosis, and make it early. Observe the babies carefully when they start to vomit. If this becomes projectile in character, definite peristaltic waves can be seen, with much distension of the stomach and rapid loss of weight, so that your baby in a very short time looks dried-out, with a tumor which can be felt at the pylorus, and the child is markedly constipated —as a rule such a child needs operative help. An x-ray picture of such a baby, with bismuth, is entirely unnecessary for diagnosis, but shows very beautifully the dilated

(Continued in Back Advertising Section, Page 26)

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CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 55 AUGUST, 1941 NO. 2

California and Western Medicine

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Address editorial communications to Dr. George H. Kress as per address above. Address business and advertising communications to John Hunton.

EDITOR . . . . . GEORGE H. KRESS

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Roster of Editorial Board appears in this issue on page 95.

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

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Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

NATIONAL HEALTH ACT AGAIN TO THE FRONT

Genesis of National Health Act.—Commenting editorially in the past, the statement has been made that, directly or indirectly, it was more than probable the so-called National Health Act (S. 1620), introduced during the last session of Congress by Senator Robert S. Wagner of New York, would again be brought to the fore. On which account, it was deemed important that members of the medical profession should remain alert to the menace involved in such a measure, and be prepared to do all in their power to carry on, in the quiescent interim, a constructive campaign for the education of the public, concerning health and medical service needs.

* * *

To Recapitulate Concerning the National Wagner Health Act.—Some brief comments:

In 1935, the Social Security Act was enacted by Congress.

In August of the same year, President Roosevelt appointed his "Interdepartmental Committee to Coördinate Health and Welfare Activities."

The "Interdepartmental Committee," in turn, appointed a group of "technical experts" to make certain studies and a report.

These "technical experts," subsequently, reported to the "Interdepartmental Committee" and, at the suggestion of the President, a consultation, under the name, "National Health Conference," was held at Washington, D. C., July 18 to 20, 1938, to discuss the report of the "Technical Committee."

The "National Health Act" of Senator Wagner may be said to have incorporated many of the recommendations of the "Technical Committee of the Interdepartmental Committee," and to have been the special result of the above activities.

* * *

Social Security Board Now Takes Up the Propaganda.—In the last Congress, the Wagner Health Act (S. 1620) died in committee. However, in the Congress now in session, similar measures have already been introduced, but owing to emergencies incident to international affairs, the pro-

† Editorials on subjects of scientific and editorial interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

posed laws lie quietly in the committee files. All this is reassuring; but too much faith should not be placed on such quiescence, as may be noted from the item that recently appeared under date of July 18, in newspapers throughout the country. Perusal of this article will indicate its significance, and in possibly influencing citizens to become favorable to legislation such as that proposed by Senator Wagner. Excerpt follows:

STEP TO LIBERALIZE SECURITY ACT URGED

Board Chief Submits Eight-Point Program, Including Provision for Health Insurance

Washington, July 18 (AP).—An eight-point program for liberalizing the Social Security Act to provide for health insurance . . . was recommended today by Chairman Arthur J. Altmeyer of the Social Security Board.

Asserting that the national defense program has created many new problems of insecurity, Altmeyer told a House committee studying worker migration that it is more essential now than ever to make progress in social security.

Altmeyer commented in a statement submitted to the committee that when the defense program arose some said there was no need for further advancement of social gains. Then he remarked that under similar circumstances Great Britain liberalized and extended its social security program and added:

"That is what Britain has done when Britain was up against bombs.

"We have made a good beginning in our social security program but that is not enough. We still do not have any social insurance program covering the risk of ill health. The method of social insurance can be applied to the problems of health just as it already has been applied in the case of unemployment, old age and death."

Recalling that some persons had expressed concern that health security might lead to "socialized medicine," Altmeyer said:

" 'Socialized medicine' is something to which I am opposed if that phrase means a system which destroys the personal relationship between the patient and his doctor. The present trouble about free choice of a doctor is that so many people have neither a choice nor a doctor. . . ."—Los Angeles *Times*.

* * *

Comment.—That Chairman Arthur J. Altmeyer, of the Social Security Board, is acting in good faith cannot be doubted. But whether he fully appreciates the full import and end-results that would accrue through enactment of a national health act such as that proposed by Senator Wagner, may be questioned. It is easy enough for Chairman Altmeyer to say:

Socialized medicine is something to which I am opposed if that phrase means a system which destroys the personal relationship between the patient and the doctor. . . .

But the question arises as to how much Mr. Altmeyer actually knows about maintaining the "personal relationship between the patient and doctor" as it prevails under the existing system of medical practice in the United States, and as it would become manifest in panel systems operating under national or statewide sickness insurance plans.

There we have the crux of the objections to governmental control of medical practice by many physicians: the panel systems and bureaucracies necessary to carry through such a governmental sickness program, would lead, without doubt, to a deterioration in the quality of medical service, and thus make worse, instead of better, whatever inadequacies may now exist in medical service under the present system. Such deficiencies can and will be eliminated through evolutionary progress, from both within and without the profession of medicine; but never by procedures certain to be brought into being through Senator Wagner's National Health (Sickness!)* Act, or similar measures.

CALIFORNIA BASIC SCIENCE INITIATIVE: SIGNATURE PETITIONS WILL BE DISTRIBUTED

On Former Procedures.—In 1927, CALIFORNIA AND WESTERN MEDICINE began the agitation for a Basic Science Law that would make it necessary for every applicant for licensure, by one of the three healing art boards of the State, to submit to such a board a statement from the California Basic Science Board (yet to be created), certifying that the applicant had shown himself possessed of proper knowledge in the basic sciences.

The first steps to promote the passage of a Basic Science Law were taken in 1926, by a special committee of the Los Angeles County Medical Association, that committee being responsible for the introduction to the California Legislature, on January 17, 1929, of "An Act to Regulate the Examination of Applicants for Licensure in the 'Basic Sciences,' to Establish a State Board of Examiners in the 'Basic Sciences.' " . . .

The California Medical Association then sponsored the movement, the local committee becoming the state committee. Agitation was continued, as may be noted by glancing at the many references to articles appearing in the OFFICIAL JOURNAL.†

* * *

Activities of Last Several Years.—In January, 1935, the campaign of education had been carried on to such extent that it was deemed desirable again to submit a Basic Science Law to the California Legislature. This was done on January 26, 1935, through Assembly Bill 1552, that being "An Act to Establish a State Board of Qualifying Certificate Examiners in the Fundamental Sciences Underlying the Practice of the Healing Arts." . . .

This second measure was in the nature of a trial balloon, to determine, somewhat, if possible, the directions from which opposition to such a law might be expected. Subsequent to this, the Council of the California Medical Association instructed its Committee on Public Relations to study and prepare a draft of a Basic Science Act. Since California is a multiple board state, with three legally recognized healing art groups to license doctors of medicine, and graduates of osteopathic and chiropractic schools, and because the osteopathic and chiropractic laws were enacted by vote of the citizens, it became necessary to draft the proposed

* "National Health Act" is a term that has alluring political appeal. For comment, in this issue, see Dr. Haven Emerson's letter on page 107.

† For list of articles on Basic Science Law, see page 104.

Basic Science Act for submittal as an initiative measure. Progress reports, made by the Committee on Public Relations, concerning the draft now completed, have appeared in California and Western Medicine.

* * *

Initiative Petitions Now Ready for Circularization.—After these many years, it is gratifying to be able to announce that the Basic Science Law is at last in final legal form, and that the necessary documents and informative literature may be in the mails when this August issue appears.

Additional information is given in this number, in the department of the Committee on Public Health Education,† the committee upon which the Council has placed the responsibility of supervision of the campaign to secure sufficient signatures to validate the initiative petition, so that it may be placed on the ballot of the next state election. Members of the Association are requested to maintain active interest, and feel free to consult their county society officers, and when the petitions are sent out for signatures, and in subsequent activities, to give fullest coöperation.

MEDICAL PREPAREDNESS

Symposia on Medical Preparedness.—In the current issue of California and Western Medicine appears a series of papers read at the annual session held at Del Monte on Thursday, May 8, 1941, as part of a symposium on medical preparedness. Members who were not present there may still wish to scan comments made by speakers representing the various military services. An equally interesting symposium is that which appeared in the *Journal of the American Medical Association* of July 19, 1941. Because of the urgency and importance of events crowding in on the people of the United States, in the solution of which members of the medical profession may be called upon to bear special responsibilities, it will be worth the time of every licensed physician to give serious thought to the problems discussed. Perusal of the papers, as a matter of fact, should make for suggestive thinking and a broader outlook on the part each doctor of medicine may be called upon to take in the near future.

* * *

Importance of Civil Practice.—These matters deeply concern physicians in civil as well as those in military practice. Today, the adult civilian population of every state is being rapidly divided into two groups: (1) Men and women concerned with essential industries, and (2) those who are not. One need only remember that, for every soldier or sailor, the work and output of at least ten civilians are needed if combat efficiency is to be maintained. Self-evident, therefore, is the place of the physician still in civilian practice, especially if he is called upon to care for any considerable number of citizens having industrial relationships.

† See page 96.

Also, in case conditions should go on to real warfare, the maintenance of morale of men in the military services can be best promoted and sustained if worries concerning illnesses of relatives left at home are kept down to a minimum. Certainly, here is abundant opportunity for genuine service by all physicians who remain in civil practice. They, also, have a real part to play.

* * *

Administration of the Selective Service Act.—In the establishment and administration, too, of the Selective Service Act, it is important that the law shall be of almost universal application, so that all citizens of certain age groups will be treated in a justly similar manner. The provision in placing, on the more than six thousand local draft boards, the responsibility of determining who should and who should not be deferred, is somewhat similar to the analogous authority resting on component county medical societies in which such units are called upon to be the sole judges as to who shall and who shall not be admitted to membership. It is evident that such plans work out to best advantage in the largest number of cases, even though, at times, errors in judgment may occur. Fortunately, as regards deferments of medical students (members of an activity that should be construed as an "essential profession"), the announcement of the Deputy Director of Selective Service, General Lewis B. Hershey, to which reference has several times been made in previous issues, has gone far in clarifying the situation, so that, in most cases, deferments are now being made. In connection with medical instruction, however, the establishment of four quarters of continuous teaching, with possible graduation at the end of three years, will make for heavy increase of burdens for many busy physicians.

To show how close at home these problems can come, mention may be made that Dr. Philip K. Gilman, who, as chairman of the California Medical Association Council, has given much time in the central office, is now in active service as a Captain, Medical Corps, U. S. Navy. Fortunately, for the time being, he is still stationed at San Francisco, where his services and advice in both medical preparedness and Council business will continue available to the California Medical Association.

* * *

Concerning Physical Disabilities of Selectees. Lately, in some quarters, much stress has been placed on the rather large number of citizens coming within the scope of the Selective Service Act, who are suffering from physical disabilities sufficient in kind or amount to make them ineligible for full military service. A study of these physical defects reveals that many are of a type that do not interfere with civilian activities. Often deficiencies of the kind recorded are remediable, but owing to the fact that they cause no constant or pressing distress, they have not been submitted for treatment. If, then, out of these examinations, will come a saner and broader approach on ways and

means through which rehabilitation measures may be instituted, publicity in regard to such disabilities may have really served a good purpose.

For further comment on these matters, readers are referred to other articles in this issue.*

C. M. A. POSTGRADUATE ACTIVITIES

Responsibilities of County Societies in After-Graduation Courses.—In common with other state medical societies, the California Medical Association has endeavored to create increased interest in postgraduate courses, and the California Medical Association Committee on Postgraduate Activities has repeatedly sought the coöperation of component county societies in efforts to promote the institution of such after-graduation or refresher studies. An analysis of the results of the last few years shows that once a successful course has been put on, physicians of such a community or district are usually anxious to have similar presentations in succeeding months or years. Progress, therefore, has been made in providing an increasing opportunity for after-graduation work but not to an extent altogether gratifying to the California Medical Association Postgraduate Committee.

It must be conceded that every component county medical society has an obligation to its members, especially to those in general practice, to bring to them practical, helpful courses, at a minimum loss of time and expense to the physicians who take part. It is here, therefore, that the California Medical Association committee desires to be of service. However, to do its part in providing speakers, and in giving publicity and other aid, it must have, in each county, an active postgraduate committee, whose members, and especially whose chairman, may be relied upon to successfully make and carry through all necessary local arrangements.

* * *

An Active Local Committee of First Importance.—Component county societies will again be approached the coming months with requests to appoint the needed committees, preferably with a staggering membership; for example, a committee of three members, one of whose terms would expire each year. In that way, the continuity of after-graduation courses could best be maintained from year to year. Once an efficient local committee is created, even if it be essentially a one-man committee, it may be wise to make no change. In some of the southern counties, where the work has been successfully carried on, this procedure is in vogue, and supervision has remained for several years with the same physicians.

At a recent meeting of the California Medical Association Committee on Postgraduate Activities, plans for a broad program for 1941-1942 were outlined. The four medical schools, the state and other health departments, county and private hospitals, and medical libraries are among the agencies whose coöperation will be solicited.

The one special and immediate need, however, as already stated, is the appointment of an active county society committee on postgraduate work. The central California Medical Association committee will then be in position to promote the attractive plans it has in mind. Practical courses on up-to-date medicine, to be made available to all physicians in both urban and rural districts, are what the state committee hopes to provide. All physicians interested should urge their county society officers to give serious thought to these matters; for an alert public desires the best to be had from scientific medicine.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 95.

EDITORIAL COMMENT†

SHOULD RHEUMATIC HEART DISEASE BE REPORTABLE?*

I

Rheumatic heart disease today accounts for 90 per cent of the heart disease among people under thirty, and the death rate is rising. There is a sound medical basis for believing the disease will require the same type of control as that which has steadily reduced the death rate of tuberculosis.

There is evidence that rheumatic infection is transmitted from person to person. The incidence of multiple cases in families equals that of tuberculosis. There have been epidemics reported in schools, colleges, military organizations; waves of rheumatic activity in cardiac hospitals are not infrequent.

The higher incidence of the disease among the lower economic groups in large cities indicates that, as in tuberculosis, better housing, provision of proper food and clothing, adequate medical care and other measures promoting child welfare can be expected to reduce the death rate.

However, any comprehensive preventive program must wait on the accumulation of adequate statistical data. We must know more about where, how and when the rheumatic disease appears. Such information can be obtained only if the disease is made reportable.

Physicians should be encouraged to report rheumatic heart disease deaths according to etiology. The International List of Causes of Death should

* See pages 68, 70, 71, 74, 75, and 95.

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

* See also Letters Department, on page 109.

be revised to permit proper compilation of the reported mortality. School nurses and teachers should be trained to be on the alert for the more easily detectable evidences of rheumatic infection, and to report such cases to the school physician for future examination. As soon as the machinery for finding and reporting the disease is set in motion, the systematic preventive program can go into action.

University of California Hospital.

Amos Christie,
San Francisco.

DELETERIOUS EFFECT OF LOCAL SERUM THERAPY

Evidence that the local application of specific immune serum may do more harm than good in certain virus diseases is one of the major surprises in recent studies of the anatomy, physiology and "metaplastic immunity" of experimental influenzal pneumonia in mice.

The concept of "metaplastic" or "selection regenerative" immunity was introduced about thirty years ago by Suzuki,[1] who deduced this theory from his studies of uranium nephritis in dogs. He found that, following sublethal uranium intoxication, regeneration of kidney epithelium took place and that the regenerated kidney is relatively resistant to uranium salts. This observation was afterward confirmed by Aschoff,[2] who pictured selective regeneration as a purposeful defensive mechanism presumably applicable to a wider variety of toxic agents. According to this concept, the more susceptible epithelial cells are killed and desquamated as a result of toxic injury, with regeneration taking place solely from the few residual uninjured and, presumably, naturally resistant cells. The theory is essentially an application of the Darwinian theory of "survival of the fittest" to histological units, and pictures adult immunity largely as a result of the toxic elimination of relatively unfit infantile tissue units.

This theory was afterward studied in detail by MacNider,[3] who was able to demonstrate two distinct regenerative processes in the canine kidney. If the convoluted tubules are not too seriously injured by uranium salts, a nonselective recovery takes place. This nonselective regeneration is not accompanied by an increase in uranium resistance. Following more serious toxic injury, however, the more susceptible epithelial cells are desquamated, and regeneration is affected solely by migrations or proliferations of the few relatively uninjured cells. Following such selective regeneration, the canine kidney will withstand at least twice the usual necrotizing dose of uranium salts.

That selective regeneration also takes place in the respiratory tract was afterward demonstrated by Straub,[4] of the Netherlands Institute for Cancer Research. He found that, following intranasal instillation of influenza virus, the infective agent shows a specific affinity for the bronchiolar epithelium. Thus electively localized the virus causes a primary catarrhal or desquamative bronchiolitis, with subsequent collapse of the pulmonary alveoli, presumably due to bronchiolar occlusion. Death is apparently due to this alveolar collapse, with resultant loss of pulmonary function. In sublethal infections, complete desquamation of the bronchilar epithelium may take place. Rapid mitoses and ingrowths of new or "metaplastic" epithelial cells may be demonstrable as early as the fourth day. Straub found that "even a very slight reepithelization gives complete immunity to subsequent influenza virus infection."

This general picture of "metaplastic" influenza immunity is currently confirmed by Taylor,[5] of the International Health Laboratories, who, however, describes the selective regeneration as an "hyperplasia," or a "conversion of columnar to stratified epithelium." As a practical application of the newer concepts, Taylor studied the cytological effects of certain therapeutic agents. He finds that in mice the maximum virus proliferation in the bronchiolar mucosa is effected within forty-eight hours after intranasal instillation, *i. e.*, before the appearance of demonstrable gross lesions. Virus proliferation is apparently inhibited at this time, with a subsequent rapid decrease in titer synchronous with onset of the regenerative process.

If, however, during this static phase of the infection the mice are given an intranasal instillation with nonisotonic salt solution, a fatal secondary proliferation of the virus takes place in practically 100 per cent of the animals. A similar exacerbation of the bronchiolitis with the development of a fatal influenzal pneumonia also follows intranasal instillation of 10 per cent normal serum. With control intranasal instillation of immune serum, however, the synergic effects are less marked, the number and severity of the pulmonary lesions being increased, but with no increase in the mortality. The most that can be said in favor of this type of immune serum therapy is that its deleterious effects are less than in control treatments with normal serum or with isotonic salt solution.

To explain his observed deleterious effects, Taylor assumes that intranasal instillation of irritating fluids tends to favor the escape of the virus from infected epithelial cells and facilitate its spread through the bronchial tree, with the resultant invasion of cells that would otherwise escape infection. This deleterious effect is apparently partly offset by the specific antibodies in immune serum, which presumably partially neutralize the escaped virus and thus prevents its subsequent invasion of new cells.

Taylor believes that there is an analogy between the lethal effects of intranasal instillation of irritating fluids in influenza mice and the usual picture of fatal influenzal pneumonia in man. In nearly all fatal human cases there is a superimposed bacterial infection, the secondary bacterial invaders usually being considered as the immediate causes

1 Suzuki, T.: "Nierensekretin," Fisher, Jena, 1912.
2 Aschoff, L.: "Lectures on Pathology," Hoeber, New York, 1924.
3 MacNider, W. de B.: Jour. Exp. Med., 49:411, 1929.
4 Straub, M.: Jour. Path. and Bact., 45:75, 1937; 50:31, 1940.
5 Taylor, R. M.: Jour. Exp. Med., 73:43 (Jan.), 1941.

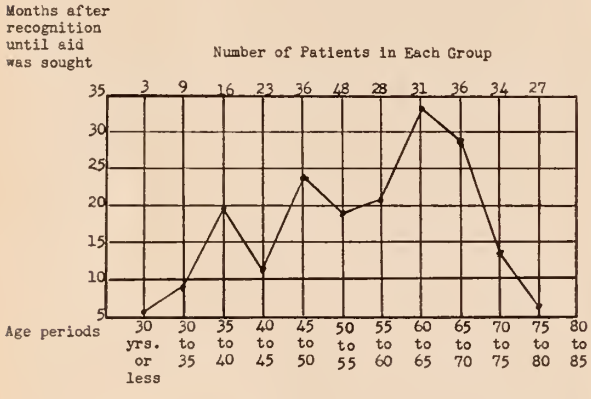
of death. Taylor pictures the secondary invaders as merely causes of an excessive virus release from infected epithelial cells, both the released virus and the bacteria contributing to the terminal pneumonia. "Such a process would explain the rather singular pathology of influenzal pneumonias, which present a certain uniformity of appearance irrespective of the type of the secondary invader."

P. O. Box 51.

W. H. Manwaring,
Stanford University.

HOW EFFECTIVE IS CANCER EDUCATION?*

To anyone who is interested in cancer and who notes the steadily mounting mortality rates, the question of adequacy of cancer education arises. For a quarter of a century the public has been told through the press, public medical meetings and the radio the initial symptoms of cancer, and has been advised to seek advice early. In reviewing a number of our records dealing with cancer of the breast, over an eleven year period from 1924 to 1935, 326 mammary cases were complete enough to study which age group of patients consult the physician first. The series has been divided into five-year groups, and the number of months elicited between the recognition by the patient of a lump in the breast, and the time until medical aid was sought, is set down. The following chart is appended:



At a glance one sees that it is the young and the old who are apparently alarmed; young persons, probably because they read more and pay more attention to their health; the old, because so many of their friends and acquaintances have died of cancer, but even these groups wait from 5 to 6 months before seeking advice. The remaining groups wait 20 months or longer before seeking aid, with the exception of the 40 to 45 age group. These women are in the menopausal age and, because this is called the critical age, they seek advice —with resultant discovery of the breast condition.

We feel that women have learned over the past five years to seek advice earlier, but the average waiting period of 20.4 months is an appallingly long time. We may infer that our educational efforts about cancer, and breast cancer in particular, have been either very inefficient or they have not reached the individuals who need it most. If this is the case, it behooves the profession as a whole, rather than a few, to aid in the publicity of annual "cancer weeks," and the individual doctor, whether he be a specialist or not, to serve as a private missionary to his patients: preaching the gospel of complete periodic physical examinations. This is the crux of the cancer problem as we now see it.

1407 South Hope Street.

Orville N. Meland,
Los Angeles.

* From the Los Angeles Tumor Institute.

MEDICAL EPONYMS

Ghon Tubercle

In a monograph of 143 pages, Anton Ghon (1866-1936), professor of pathological anatomy at the German University in Prague, discussed *Der primäre Lungenherd bei der Tuberkulose der Kinder* [*The Primary Lung Focus in Childhood Tuberculosis*] (Berlin u. Wien, Urban u. Schwarzenberg, 1912). A portion of the translation follows:

> My investigations go back to the year 1903. They originated without any knowledge of the work of Küss. . . . The results of my studies confirm the findings of Küss and H. Albrecht. They consequently contribute nothing essentially new.
>
> We found primary lung foci in more than 75 per cent of our cases. . . . If . . . the number of primary lung infections should be reduced to even 90 per cent, they would still justify the conclusion that in the child, the primary infection of the lung is the usual form of tuberculosis infection. Surely, this fact has great practical significance.—R. W. B. in *New England Journal of Medicine*, February 6, 1941.

* * *

Graves's Disease

Exophthalmic goiter was described by Robert J. Graves (1797-1853), of Dublin, in Lecture No. 12 in a series of clinical lectures delivered at the Meath Hospital during 1834-1835. The lecture is reported in the *London Medical and Surgical Journal* (II, 7:513-520, 1835) under the following title: "Persesquinitrate of Iron in Chronic Diarrhoea—Blueness of the Fingers and Toes in Fever—Some Account of the Yellow Fever Which Prevailed in Dublin in 1827—Newly Observed Affection of the Thyroid Gland in Females: Its connexion with palpitation, with fits or hysteria—Erysipelas—Remarks on the Formation of Acidity of the Stomach in Indigestion—Psoriasis—Treatment by Arsenic." Apparently the subject was considered of relatively minor importance.

> I have lately seen three cases of violent and long continued palpitations in females, in each of which the same peculiarity presented itself, viz., enlargement of the thyroid gland; . . . When the palpitations were violent the gland used notably to swell and became distended. . . . The swelling immediately began to subside as the violence of the paroxysm of palpitation decreased. . . . In one the beating of the heart could be heard during the paroxysm at some distance from the bed. . . .
>
> . . . We may expect to observe the tumefaction of this gland also where the palpitation depends on organic disease of the heart, as in the following case detailed to me by a friend.
>
> A lady, aged twenty, became affected with some symptoms which were supposed to be hysterical . . . it was observed that her pulse had become singularly rapid . . . being never under 120. . . . She next complained of weakness on exertion, and began to look pale and thin. Thus she continued for a year. . . . It was now observed that the eyes assumed a singular appearance, for the eyeballs were apparently enlarged, so that when she slept or tried to shut her eyes, the lids were incapable of closing. When the eyes were open, the white sclerotic could be seen, to a breadth of several lines, all around the cornea. In a few months, the action of the heart continuing with unceasing violence, a tumor, of a horse-shoe shape, appeared on the front of the throat and exactly in the situation of the thyroid gland.—R. W. B. in *New England Journal of Medicine*, February 27, 1941.

ORIGINAL ARTICLES

PROBLEMS OF ADRENAL INSUFFICIENCY*

ROBERT F. LOEB, M. D.
New York City, New York

DISTURBANCES IN PHYSIOLOGY

THOMAS ADDISON, in 1855, pointed out for the first time that "universal disease of the capsules" is incompatible with life and stated that aside from this observation the function of these structures "is almost, or altogether, unknown." At the same time, Addison predicted that the further study of disease of the adrenal glands might lead to some understanding of their physiological activity. This prophecy has in recent years been amply fulfilled and it is to a consideration of problems of the functions of the cortex of the adrenal glands and the treatment of adrenal insufficiency that I should like to call your attention.

The physiological disturbances known to be present in adrenal insufficiency may be divided into two general categories. The first of these groups of disturbances is associated with abnormalities in behavior of certain of the electrolytes and water. The disturbances are, in part, reflected by the changes in concentration of certain substances in the blood serum in patients suffering from "decompensated" Addison's disease as shown in the slide. Among the abnormalities to be observed are a decrease in the sodium concentration, an increase in potassium, retention of nonprotein nitrogen, and an increase in serum protein concentration associated with loss of water from the blood. These changes which appear to have as their point of departure an abnormally great loss of sodium salts and water through the kidneys give rise to a decrease in renal function as characterized by diminution in creatinin and urea clearances as well as a decrease in ammonia excretion by the kidney. It seems highly probable that these changes in renal function can be attributed to a decrease in plasma volume and a consequent decrease in renal blood flow. Whether or not specific changes in the cells of the renal tubules also contribute to these changes in renal function as they probably do in relation to the disturbances in sodium, potassium and water, we do not know. The development of hypotension which may reach extraordinarily low levels in the crises is also in part to be attributed to the disturbances of salt and water metabolism. The clinical significance of the sodium ion and water in relation to this category of disturbances in adrenal insufficiency was first demonstrated by the group working at the Presbyterian Hospital in New York nine years ago at which time we found that the simple procedure of the restriction of the amount of sodium chlorid in the diet would induce an alarming adrenal crisis in a well-compensated Addisonian patient and that the administration of salt without the aid of other procedures would frequently alleviate this condition.

The second category of physiological disorders demonstrable in adrenal insufficiency is that dependent upon abnormalities of carbohydrate metabolism. In 1909 Porges first demonstrated the presence of hypoglycemia both in patients with Addison's disease and in adrenalectomized animals. At that time this disturbance was thought to be due to destruction of the adrenal medulla. Later Britton and Silvette, on the basis of extensive experiments, maintained that the disturbances present in carbohydrate metabolism resulted from cortical rather than medullary adrenal insufficiency. This point of view was not accepted by most workers in the field but in recent years it has received ample confirmation on the basis of the studies of C. N. H. Long and his coworkers, by the studies of Kendall and others at the Mayo Clinic, and by Thorn and his associates in Baltimore. In patients with Addison's disease, disturbances of carbohydrate metabolism are manifested by mild spontaneous hypoglycemia which is demonstrable in most patients at some time and which is severe in about 25 per cent of the cases. Striking sensitivity of Addisonian patients to small doses of insulin offers further evidence of disturbed carbohydrate metabolism. It is possible that some of the feeling of muscular weakness exhibited by Addisonian patients as well as some of the diffuse and focal neurological disturbances occasionally encountered result, at least in part, from disturbances in carbohydrate metabolism. In animals, particularly in the cat and rat, the tendency to hypoglycemia and insulin sensitivity following adrenal ablation occurs with greater regularity than it appears to do in man and in the operated dog.

The influences of the adrenal cortex upon carbohydrate metabolism are readily demonstrable in the rat. Thus Long and also Kendall and his coworkers find that the administration of adrenal cortical extract to normal mice and rats increases glycogen storage in the liver. They have also shown in partially pancreatectomized animals that the administration of cortical extract increases glycosuria and nitrogen excretion and they have also demonstrated in phlorizinized animals that the excretion of glucose and nitrogen increases in such a way that the complete D/N ratio of about 3.4 is developed. In other words it appears as though adrenal cortical extract in these animals acted as "anti-insulin." It remains for the future to determine whether or not these changes in carbohydrate metabolism initiated by adrenal cortical hormones are due to a direct effect on carbohydrate metabolism resulting from a decrease in its utilization or whether these hormones influence carbohydrate metabolism indirectly by increasing protein breakdown and glucose formation, i. e., gluconeogenesis, as suggested by Long.

Intimately related to the disturbances in carbohydrate metabolism observed in adrenalectomized animals is the capacity for physical work. Ingle has shown repeatedly that the steroids of the adrenal

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cortex which have the greatest effects upon carbohydrate metabolism are the same as those which have the greatest effect in restoring the "work capacity" of the adrenalectomized rat. Ingle has also shown that this "work capacity" of the adrenalectomized rat is only slightly increased by the life-maintaining hormone which has its effects only on electrolyte and water metabolism.

In the foregoing discussion I have dealt with the two categories of disturbances known to be present in adrenal insufficiency. I should like now to speculate briefly concerning the possibility of a third category. A certain number of patients with Addison's disease die with what appears to be typical Addisonian death characterized by profound asthenia, falling blood pressure and a small or soft pulse. These changes may develop without apparent relation to the state of the electrolyte and water metabolism and are apparently unrelated to the level of the blood sugar. Furthermore, these patients, at times, fail to respond to what may be considered adequate therapy with active hormonal substances as judged by their effects on the water content of the blood, concentration of electrolytes in the blood and the maintenance of blood sugar. In other words a number of patients die Addisonian deaths usually associated with a terminal rise in temperature and a sharp decrease in blood pressure but without the expected chemical changes. Whether these patients suffer from a central disturbance of the vasomotor apparatus or from purely peripheral vasomotor changes is not apparent, but it seems fairly certain that a disturbance of the vasomotor system is present. Whereas this possibility is speculative, it seems important that it be borne in mind, and that we recognize that disturbances apart from the two categories described may exist.

Before proceeding to a discussion of therapy I should like to consider briefly the present state of our knowledge concerning the steroids of the adrenal cortex and their physiological effects. At the present time, more than twenty of these substances have been isolated from adrenal glands in crystalline form. Of these, there are four with demonstrable physiological activity. It is of great interest that the nature of the physiological activity is dependent upon the chemical structure in general and upon the number and location of oxygen atoms in particular. Thus, desoxycorticosterone, the only steroid thus far synthesized and the only one available commercially, has striking effects upon electrolyte and water metabolism and it has no significant effect upon carbohydrate metabolism. On the other hand corticosterone, dehydrocorticosterone and "compound E" of Kendall, which is 11-dehydro-17-hydroxycorticosterone, contain four or five oxygen atoms and have striking effects upon carbohydrate metabolism in rats and only slight effects upon salt and water metabolism. Of the carbohydrate-active steroids "compound E" of Kendall has the greatest potency. The steroid residue which remains after the extraction of the crystallizable compounds from adrenal glands has, curiously enough, a life-maintaining activity greatly in excess of that of desoxycorticosterone. Whether or not the various steroids isolated represent degradation products of one "mother compound" is not known at the present time. In other words, there remain tasks for the chemists in the isolation of other active compounds and in the synthesis of any with an effect on carbohydrate metabolism.

TREATMENT

I should like now to consider the problem of the treatment of Addison's disease. The treatment of Addison's disease, like that of diabetes mellitus, should be directed primarily toward (1) the specific replacement of the hormone or hormones lacking, (2) the correction of the physiological disturbances which ensue as a consequence of this endocrine deficiency, and (3) the avoidance of factors known to intensify manifestations of the disease. The nature of the therapy and the vigor with which it must be applied vary tremendously with the phase of the disease present. In the patient whose disease is well compensated, a few general measures such as the avoidance of physical and mental fatigue, the immediate care of even mild acute infections, and the ingestion of a liberal amount of sodium chlorid will suffice to maintain moderately good health for periods of months or even years. On the other hand, with the appearance of a crisis, whether it occurs in the natural progression of the disease or whether it results from known causes, a number of active therapeutic measures may have to be applied promptly and intensively in order to combat successfully the grave and often fatal loss of inorganic base with its attendant dehydration and peripheral circulatory collapse. Procrastination and inadequate treatment of the crisis sacrifices patients who might otherwise be restored to a useful existence.

At the present time three therapeutic agents are at our disposal in the treatment of established adrenal insufficiency, i. e., Addison's disease. These include (1) sodium salts, (2) desoxycorticosterone esters, and (3) adrenal cortical extracts. The results which may be anticipated with these various therapeutic agents are naturally dependent upon their effectiveness in correcting the physiological disturbances known to be present. Thus it might be expected that salt and desoxycorticosterone would tend to rectify the disorders of electrolyte and water metabolism. It might be expected also that cortical extract which contains a mixture of steroids, would correct disturbances in carbohydrate metabolism as well as those of salt and water and in addition increase muscular strength.

The results of treatment of one patient, I might add the first in whom salt treatment was tried, are shown on the slide. These results have been duplicated on many occasions in many patients and are probably familiar on the basis of your own experiences. Patients receiving salt for the purpose of maintenance usually require 10 to 18 grams a day in enteric-coated tablets or in 1 per cent solution. Only a few are able to tolerate large amounts of salt in capsule form. In a crisis, infusions of 3 to 4 liters of normal salt solution a day are usually necessary to relieve extreme weakness, marked

hypotension and gastric intolerance. It is rather surprising how frequently this simple form of therapy meets with success in restoring a critically ill Addisonian patient to relatively good health and how effective it proves in maintaining a normal electrolyte pattern in the blood in the majority of patients with disease of the adrenal cortex. On the other hand the limitations of salt therapy are made apparent by the fact that only three of a group of approximately 30 patients in our clinic are now being continued on this regime. These three patients have had the diagnosis established either by having a crisis induced through salt withdrawal or by admission to the hospital with spontaneous adrenal cortical decompensation. These patients who have been on salt for 7½, 6 and 1½ years respectively are able to work and cannot be persuaded to use synthetic hormones. Many patients who were formerly maintained on salt alone are now receiving synthetic hormone and have shown further improvement.

This brings us to a consideration of the effects and limitations of treatment with desoxycorticosterone. This steroid was both isolated and synthesized by Reichstein in Zurich in 1937. Desoxycorticosterone acetate is, as you know, administered subcutaneously or intramuscularly in an oil medium, or by pellet implantation as first practiced by Levy-Simpson in England and by Thorn in this country or by sublingual instillation in a solution of propylene glycol as recently recommended by Doctor Anderson in San Francisco. The striking physiological activity of desoxycorticosterone in patients with Addison's disease is summarized in the slide. In addition to the changes shown there are obvious changes in electrolyte excretion, i. e., sodium chlorid retention and augmentation of potassium excretion. It should be pointed out that there is a wide difference in the response of patients to desoxycorticosterone and that the reasons for these differences are not apparent. For example, one of our patients gained 11 kilos in ten days. Another patient on the identical regime gained only 2 kilos in thirty days even though his dosage of hormone was greater. In connection with the effect of this hormone on salt and water retention, it is of interest that we have encountered patients in whom it has been impossible to raise the blood sodium level to normal although the capacity for salt and water retention and edema formation appeared unlimited.

Desoxycorticosterone, as has been stated, has no demonstrable effects on carbohydrate metabolism and its effect on pigmentation is doubtful.

It is beyond the scope of this paper to discuss details of therapy but it may be stated that most Addisonian patients require a maintenance dose of desoxycorticosterone varying between 1 and 7 milligrams daily given subcutaneously and without the addition of salt beyond that present in the usual diet. On this regime most patients have made extraordinary gains as far as their sense of well-being, their strength, their appetite, their weight, and their outlook on life are concerned. Some are at work and others are, from the point of view of strength, capable of undertaking their normal activities.

It is virtually impossible to lay down general rules for treatment in a situation in which the responses of patients vary as widely as they do in acute adrenal insufficiency, i. e., in severe crises. With this viewpoint in mind, I cannot be more specific than to say that 10 milligrams of desoxycorticosterone in oil given twice a day and repeated infusion of glucose in normal saline often constitute the treatment needed to restore the patient. In any event constant vigilance is required to steer a course midway between undertreatment and overdosage with the hormone.

Two years ago we reported the clinical and physiological evidences of overdosage with desoxycorticosterone therapy. The subjective evidence consists of increasing puffiness of the face, swelling of legs or even anasarca, tightness in the chest, palpitation, dyspnea and orthopnea, weakness and sometimes headache. Objectively the signs are those of congestive heart failure with fluid accumulation, enlargement of the heart, congestion of the lungs, increase in venous blood pressure, decrease in vital capacity, and increase in the cardiac silhouette as revealed by x-ray. The blood may show strikingly hypoproteinemia and the potassium content of the serum may be sharply reduced. In the control of therapy, the rapid gain in weight, the development of edema, pulmonary râles, decrease in vital capacity and decrease in serum protein below about 5.5 per cent constitute the most practical signs of overdosage. Recently, we have attempted without success to reproduce this syndrome of fluid retention and cardiac failure in dogs. Instead, normal dogs receiving large doses of desoxycorticosterone in the course of two weeks develop two different but equally dramatic syndromes. One of these bears resemblance to diabetes insipidus. The other syndrome is that of intermittent periodic paralysis characterized by marked weakness of the neck and leg muscles associated with a sharp decrease in serum potassium concentration. This syndrome can be prevented or relieved by the administration of potassium salts. The muscles in the paralytic dogs who ultimately die of this disorder show a curious fragmentation of muscle fibers, and on chemical analysis the muscles are found to have as much as 30 per cent of the intracellular potassium replaced by the sodium ion.

Having discussed the rôle of salt and desoxycorticosterone in the treatment of adrenal insufficiency, I should like to mention the action of cortical extract and one of the crystalline steroids, i. e., corticosterone, which is isolated from the adrenal glands, and which in animals affects carbohydrate metabolism and "work capacity."

Through the courtesy of the Roche-Organon Laboratories, which have provided us with all of our adrenal preparations, we were able last year to compare the effect of desoxycorticosterone, corticosterone and cortical extract upon electrolyte and carbohydrate metabolism. For this purpose one of our Addisonian patients was maintained on a constant metabolic regime and was given 6 milligrams

of desoxycorticosterone daily, i. e., enough to prevent the development of acute cortical insufficiency. After adequate control observation he was given an additional dose of 20 milligrams of desoxycorticosterone daily for a period of 5 days and after two more 5-day periods on the standard régime he received 18.2 milligrams of corticosterone daily for 5 days. After further control periods he was given 21 cubic centimeters of cortical extract daily. From the slide it will be seen that desoxycorticosterone had a striking effect upon sodium excretion and less upon potassium excretion. Whereas corticosterone and cortical extract had demonstrable effect in the same direction, they were insignificant in comparison with desoxycorticosterone. Thorn had shown earlier that cortical extract influenced electrolyte excretion in patients with Addison's disease, but he too showed that enormous amounts are necessary to produce a very small effect. Thus it is apparent that cortical extract has little to recommend it for the correction of salt and water disturbances in comparison with desoxycorticosterone.

As has been stated, it might be anticipated that cortical extract and corticosterone would have a greater effect upon carbohydrate metabolism than would desoxycorticosterone. In our studies, no difference was observed in their influence upon the fasting respiratory quotient. The effects on glucose tolerance curves are shown in the slide. In the light of our knowledge of the effects of corticosterone and cortical extract upon carbohydrate metabolism in rats, it seems possible that the difference in sugar curves obtained by us with the patient on a constant régime may have some significance, but it certainly is not enough to be of clinical value since, at the end of three hours, the blood sugar level fell to about 50 milligrams per cent with all preparations.

On the basis of these studies we are forced to the conclusion that the virtues of cortical extract over those of desoxycorticosterone are essentially theoretical and that small doses of extract, i. e., less than 5 cubic centimeters, have probably little effect unless it be psychological. It is possible that cortical extract may contain some substance, the physiological activity of which we cannot yet measure. I say this because of the fact that some patients receiving this preparation maintain that they "feel better" even though no demonstrable chemical or physiological change can be observed. The unsatisfactory nature of this type of evidence is obvious, but perhaps is deserving of some consideration.

This brings me to one point of general interest which I should like to discuss before closing. We all encounter a large number of patients who complain of the syndrome characterized by exhaustion, fatiguability and anorexia associated with varying degrees of hypotension. This exhaustion state appears in the course of malignant disease, it is often encountered during and after acute or protracted infectious diseases, it follows serious surgical procedures with considerable regularity, it frequently follows severe emotional strain and is occasionally encountered without any known association. Whether or not this exhaustion syndrome has a single underlying physiological basis, I do not know. The question which concerns us is whether it may be ascribed to "functional adrenal insufficiency." This I also do not know. In contrast to patients with unequivocal adrenal insufficiency these patients show no evidence of disturbances of electrolyte and water metabolism either spontaneously or as a result of salt withdrawal. Nor is there any apparent disorder of carbohydrate metabolism, and yet their symptoms are often more intense than are those of patients with only partially controlled Addison's disease. On the other hand, Weil and Browne have shown that the urine obtained from patients who have undergone operation or who have acute infections contains substances which protect young adrenalectomized rats from the fatal effects of chilling as does adrenal cortical extract, whereas the extract of normal urine possesses no such properties. These studies do not establish the fact, however, that the substances recovered from the urine of patients under various types of stress are adrenal in origin.

I fear that the ultimate solution of the problem of exhaustion states as well as many other problems mentioned this morning must be left to the future.

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SURGICAL LESIONS OF THE ADRENAL GLANDS*

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THE development which has occurred in the recognition of certain surgical lesions of the ductless glands has resulted from a combination of studies by clinician, internist and experimenter. The enthusiasm of each in turn aroused the others, with the result that all have become endocrine conscious. In spite of the tendency to overestimate the value of certain of the hormones and glandular preparations, endocrinologic studies have resulted in brilliant achievements in diagnosis, therapy and pure science.

Diseases of the ductless glands usually are accompanied by quantitative and, possibly, by qualitative alterations in secretory activity. In the adrenal glands or in the pituitary body, in each of which the gland is composed of two or more separate functional units, the disease may be manifested by clinical pictures which suggest hyperfunction of one unit and hypofunction of the other. These mixed types of conditions may be exceedingly difficult to interpret on a physiologic basis. Further adding to the complexities of the problem is the fact that patients who present endocrine disturbances may be suffering from associated abnormalities of one or more of the ductless glands as well.

Clinically and experimentally, Marine and Jaffe have shown that an intimate relationship exists

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between the adrenal and the other ductless glands. The so-called Cushing syndrome, thought to be the result of basophilic adenomas of the pituitary body, is characterized by heterosexual changes which are similar to those presented by patients who have adenomatous and hyperplastic lesions of the cortex of the adrenal gland. Several observers [11, 12, 18, 19] have called attention to the fact that a particular tumor of the ovary, the arrhenoblastoma, which is composed essentially of testicular tissue, also produces heterosexual changes, but in the presence of this tumor the configuration of the body tends more toward the masculine type than occurs among female patients with hyperfunctioning adenomas of the adrenal cortex.

Since the gonads and the adrenal cortices have a common embryologic origin, it is not surprising to find that both structures have cells with common histologic characteristics and secrete hormones which have similar chemical formulas.*

The symptoms depend on the age and sex of the patient at the onset of the illness, the type of tumor, the degree of its endocrine activity, and the duration of the disease. Adrenal cortical tumors occur most frequently among young women, although in our series of cases in which operation was performed two of the patients were children; one was nine years of age and the other was two years.

When a hyperfunctioning tumor occurs after puberty the changes which tend to reverse the sex occur, such as virilism of women and feminism of men. By virilism of women is meant the growth of hair with masculine distribution, some beard or mustache, atrophy of the breasts, masculine habitus, cessation of the menses, atrophy of the reproductive organs, and hypertrophy of the clitoris. On the other hand, when the disease originates among children, precocious puberty usually occurs. Among boys the precocious puberty is likely to be of the masculine type with the precocious development of external genitalia of the mature type. Among girls the puberty is heterologous, that is, it tends to progress along masculine lines with hypertrophy of the clitoris, deepening of the voice, masculine distribution of hair, and interestingly enough, sometimes with precocious menstruation. In one of our cases, the patient, who was a child, aged 2 years, had had two or three menstrual periods.

SIMILARITY OF SYMPTOMS

Difficulty in diagnosis arises from the fact that in some instances the symptoms resulting from adrenal cortical tumors may resemble closely those that occur in Cushing's disease (basophilic adenoma of the pituitary body). The latter disease occurs for the most part among young women, and in contrast to adrenal cortical tumors (which vary in their clinical manifestation) produces a rather constant clinical picture. In pituitary basophilism the clitoris usually is not enlarged but absence of this finding does not exclude a tumor of the adrenal cortex. At present there is no single clinical criterion which can be used to differentiate the two conditions. The consequence of this fact is that the presence of adrenal cortical tumor should be excluded in all cases in which the symptoms of Cushing's disease are present. To our minds, this is most accurately done by exploration of the adrenal glands.

We feel that in case of doubt the adrenal glands should be explored surgically, provided the clinician is familiar with the early symptoms of acute adrenal insufficiency and if adequate facilities are at hand for treatment of this emergency should it arise. There are two objections to this viewpoint: first, an appreciable number of patients will be disappointed because no benefit results from the operation; and second, it has been stated that in cases in which advanced symptoms of basophilism are present there is considerable danger of infection. In our experience this has not interfered with postoperative progress in cases in which cortical tumors are not found; in two cases Cushing's disease was discovered at necropsy months after the patients had been dismissed from observation. Certainly there is little justification for the death of patients who receive roentgen therapy of the pituitary body when the lesion responsible for their symptoms is an adrenal cortical tumor which might have been eradicated successfully had the patient been operated on early in the course of the disease. At the same time, when it is desired, one can open the peritoneal cavity and examine the ovaries to exclude the possibility of masculinizing tumors of the ovaries (usually arrhenoblastomas) and very rarely, granulosa cell tumors which result in the male type of hirsutism, amenorrhea and hypertrophy of the clitoris. However, such tumors practically never cause diabetes, hypertension, osteoporosis, or incidental symptoms of the other conditions associated with adrenal cortical tumors, although the recent case reported by Norris is one of the few exceptions to this rule.

Among children tumors and inflammatory processes in the region of the pineal body and contiguous structures may be associated with sexual and somatic processes. Finally, there are, in addition, many women who have varying degrees of hirsutism, hypertension and debility for which no adequate basis can be found.

TUMORS OF THE ADRENAL MEDULLA

Although there is a variety of tumors which originate in the medullary substances of the adrenal glands, the most important surgically are the paragangliomas, which frequently are called "pheochromocytomas." They are benign. The similarity of origin of the sympathetic nervous system and the adrenal medulla explains paroxysmal hypertension, the characteristic symptom of these medullary tumors. Excellent results have persisted for many years following removal of adrenal paraganglioma, as reported by Mayo, Shipley, the Porters and myself.[20]

* The chemical similarity between the members of the group of male and female sex hormones has been appreciated for some time. More recently it has been shown that crystalline compounds of similar chemical structures, which are capable of maintaining the health of adrenalectomized animals, can be extracted from the adrenal cortex.

Adrenal medullary tumors occur with much less frequency than those involving the cortex and few cases have been reported in the literature. Paroxysms of hypertension accompanied by vasomotor phenomena such as pallor, tachycardia, headache and apprehension are the characteristic symptoms associated with adrenal medullary tumors. Sweating is another of the vasomotor phenomena which occur in some cases, although sweating does not occur after an injection of epinephrin. Precipitation of these paroxysms is brought about by undue physical and mental exertion and they can be precipitated experimentally by the "cold test" [4, 5] (the introduction of the feet or the hands into water at a temperature of 4 degrees Centigrade for one minute). The appearance of the patient and the physical signs are of little help in making the diagnosis unless the tumor is of sufficient size to be palpated during abdominal examination or to depress the kidney abnormally, as shown by urographic examination; this depression was not evident in four cases observed at the clinic. In one case, which was reported by Borch-Johnsen, the tumor had attained a huge size and weighed 3,000 grams.

Patients who have hyperfunctioning adrenal medullary tumors withstand surgical procedures very poorly.[1, 14] One of the characteristics of hyperfunctioning adrenal tumors is their tendency to cause sudden death. There are a number of instances on record in which the tumor was discovered accidentally at necropsy subsequent to sudden death after minor or major surgical procedures, such as extraction of a tooth, hemorrhoidectomy or amputation of a gangrenous extremity.

Owing to the relative infrequency of tumors of the adrenal medulla the possibility of their presence is not likely to be suspected. In one of the four cases seen at the clinic, the diagnosis was made before operation and in another case the tumor was found after the unusual persistence of hypertension subsequent to bilateral splanchnic resection. In the third case, which was reported by Dr. C. H. Mayo, the tumor was suspected preoperatively and was found at abdominal exploration. In these three cases the patients survived and no further paroxysms of hypertension have occurred. In the fourth case the tumor was discovered at necropsy. In one of these cases the hypertension tended to be continuous rather than paroxysmal. It must be remembered that paroxysms of hypertension occasionally may occur in the absence of medullary cortical tumors. We have seen one such case in which the only important postmortem finding was petechial hemorrhages in the pons.

GANGLIONEUROMAL TUMOR

Thus far, I have referred to the most important surgical lesions of the adrenal medulla, namely the paragangliomas, which are benign. Another benign tumor, the ganglioneuroma, produces no characteristic clinical symptoms and usually is found unexpectedly at necropsy. Malignant tumors which involve the adrenal medulla are the neuroblastomas which metastasize early to the liver and lungs among adults and to the skull and long bones among children. The diagnosis of these lesions usually is made only after metastasis has occurred. On this account surgical treatment directed toward their removal is without benefit. The usual preparation of patients for surgical procedures is all that is required preliminary to operation in cases of adrenal medullary tumors. In cases of hypertension in which tumor of the medullary portion of the adrenal gland has been suspected but not found on exploration, Craig and I have been dividing the major, minor, and lesser splanchnic nerves as they descend through the diaphragm and have been resecting a portion of the celiac ganglion. In addition, we have removed at the same time the lumbar sympathetic trunk also.

The treatment of tumors of the adrenal gland is, of course, surgical removal of the tumor. At the Mayo Clinic nine cortical tumors and three medullary tumors have been removed without any mortality.[21, 22] Two of the cortical tumors were very large and weighed 600 grams and 800 grams respectively, whereas the others averaged approximately 10 to 15 grams and measured 2 to 4 centimeters in diameter. Although microscopic examination revealed early malignant changes in all of the cortical tumors, in five cases the tumor was encapsulated definitely and recurrence has not taken place. In the two cases in which the cortical tumors were very large, penetration had extended beyond the capsule; the growth was attached to the diaphragm in one case and to the inferior vena cava in the other case. In both cases the lesions were malignant; there were signs and symptoms of recurrence and both patients died within two years after the operation. The three medullary tumors which were removed were encapsulated and benign.

POSTOPERATIVE CONTROL

The most important factor in surgical therapy of the cortical tumors is the anticipation, prevention and control of postoperative adrenal cortical insufficiency. This consists essentially of the preoperative and postoperative administration of potent extracts of the adrenal cortex* and parenteral and oral administration of adequate amounts of fluids to which have been added solutions of sodium chlorid and sodium citrate, and the administration of a diet that is low in potassium. These procedures tend to control the impending adrenal cortical insufficiency which has probably been responsible for the high mortality rate (50 per cent previously reported by Lukens and his associates, by Cahill and his associates and by Scholl). The method outlined is essentially that which, at the clinic, has been found to be effective in controlling various degrees of adrenal insufficiency in Addison's disease and has been used in all of our cases of suspected adrenal cortical tumors. Its effectiveness is illustrated by operative recoveries in nine cases; in three of the cases the

* We have been fortunate in having at all times an ample supply of potent extract prepared by Kendall. Before using any one of the commercial preparations one should have had, if possible, some experience with its use in the treatment of acute adrenal insufficiency as it occurs in Addison's disease. The dosage necessary may be considerably larger than that recommended by the manufacturers.

adrenal glands on the opposite side were found to be atrophic.

Although transthoracic, transpleural and retroperitoneal approaches to the adrenal glands have been carried out, in our opinion the approach which gives the best opportunity for minute and careful inspection of the gland is through a posterio-lumbar incision similar to that used in exposing the kidney. After the fascia of Gerota has been incised, the perirenal fat is reflected from the upper pole of the kidney and the kidney is retracted downward; this exposes the inferior and posterior aspects of the adrenal gland. It is possible, in this manner, to study the gland accurately from every side without disturbing the circulation. Care is taken to prevent injury to the blood vessels which enter the adrenal gland on its mesial and posterior aspect. Although we have seen one case of small multiple adenomas, minute in size, in other cases adenomas have been recognized grossly with ease; these have varied from 2 to 15 centimeters in diameter. When larger tumors are present, practically the entire adrenal gland may be thinned out and destroyed, with the exception of a fringe a few millimeters in length, which can be recognized by its brilliant yellow color as being adrenal cortical tissue. It must be remembered that on the right side the adrenal gland will be found to be in direct contact with the inferior vena cava. Usually, the blood vessels supplying an adrenal tumor are much larger than the blood vessels which supply the normal adrenal gland. On this account, care must be taken to ligate them accurately.

PRIMARY OR SECONDARY HYPERTROPHY AND HYPERPLASIA OF THE SUPRARENAL CORTEX WITH HYPERFUNCTION

My remarks relative to that large group of cases in which hyperfunctioning adrenal tumors are not found at operation but in which various degrees of hypertrophy and hyperplasia of the adrenal glands are present may seem like an anticlimax to the preceding discussion. A similar condition exists, however, in those cases of hyperinsulinism in which exploration of the pancreas fails to reveal the presence of hyperfunctioning adenoma of the islands of Langerhans. There is an assumption that such cases, like those in which there is clinical evidence of hyperfunction of the adrenal cortex but in which adenomas are not found, may simulate in their activity cases of Graves' disease, in contrast to cases of hyperfunctioning or toxic adenoma of the thyroid. In cases of Graves' disease the beneficial effects of subtotal thyroidectomy have long been recognized. Although some beneficial results have been obtained by subtotal pancreatectomy in cases of hyperinsulinism without adenoma, by and large our experience with partial removal of the adrenal glands has been disappointing. On the other hand, in two of the cases in which the enlarged adrenal gland was not disturbed and in which roentgen therapy was given in the region of the pituitary gland, remarkable degrees of regression in signs and symptoms occurred, leading one to suspect that the primary lesion was in the pituitary gland. In one case in which surgical exploration of the adrenal glands was made, the patient would have recovered had it not been for the development of a septic sore throat on the fourteenth postoperative day when the patient was ready to leave the hospital; at postmortem examination serial sections of the pituitary gland revealed no evidence of tumor. This patient, by the way, was the only one seen at the clinic since 1923 [7] who failed to recover from surgical exploration of the adrenal glands or removal of adrenal tumors. Another patient died while under observation at the hospital. She presented a picture of either pituitary basophilism or hyperfunctioning tumor of the adrenal cortex. At necropsy evidence was not observed of either condition, although there were some hypertrophy and hyperplasia of each adrenal gland. In this case, again, serial sections were made of the pituitary glands without discovery of a basophilic adenoma. There was present, however, a thymoma.

SUMMARY

The most frequent surgical lesions of the adrenal glands are the hyperfunctioning adenomas of the cortex and the pheochromocytomas of the medullary portion of the glands.

Since the gonads and the adrenal cortices have a common embryonic origin, they have cells with common histologic characteristics and secrete hormones which have similar chemical formulas. The symptom complex produced by hyperfunctioning tumors of these structures is characterized by heterosexual changes accompanied by the development of some masculine characteristics in the female and some feminine characteristics in the male. Variations in these changes occur, depending on the sex of the patient and the age at the onset of the illness. For example, among girls precocious puberty is an outstanding symptom of the tumors, whereas among boys precocious development of the mature type of the external genitalia is outstanding. Hyperfunctioning of the adrenal cortices may occur secondary to basophilic adenomas of the pituitary gland, in which case the clinical picture is not unlike that of hyperfunctioning cortical tumors.

The medullary paragangliomas, frequently designated "pheochromocytomas," are benign, and since the embryonic origin of the sympathetic nervous system and the adrenal medulla are the same, the characteristic clinical picture is that of paroxysmal attacks of hypertension.

The diagnosis of tumors of the adrenal glands remains a problem which I believe is best met by surgical exploration of the glands in cases in which presence of the growths is suspected. Although injections of air around the adrenal glands have assisted in localizing large tumors by roentgenologic examination, the procedure produces a definite mortality rate and should be used only with the greatest caution.

Since we reported a case in 1924, in which death occurred subsequent to operation on the adrenal gland, we have had but one such case in which recovery failed to follow surgical intervention. The patient in the latter case had recovered from her operation and was ready to leave the hospital when she succumbed to a septic sore throat.

Subsequent to removal of adenomas of the adrenal cortex, regression of the signs and symptoms rapidly occurs and the prognosis is excellent. After removal of hyperfunctioning medullary tumors the paroxysmal hypertension disappears.

Mayo Clinic.

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MEDICAL PREPAREDNESS IN CALIFORNIA*

PHILIP K. GILMAN, M. D.
San Francisco

IT is a pleasure to stand before you this morning and to report that the medical profession in California has coöperated 100 per cent in the national plans for mobilization of medical resources. I do not mean that statement to be taken as bragging on my own part as chairman of the California Committee on Medical Preparedness; I have been only one cog in a rather large wheel which extends throughout the State and which encompasses the activities of a large number of physicians.

If you will bear with me for a moment, I should like to give you a brief review of the activities of this particular committee. The committee came into being in July, 1940, when the American Medical Association held an organization meeting of its National Committee on Medical Preparedness. The national committee appointed one member in each state to act as a state representative. That member, myself in the case of California, appointed one member in each county as a member of the state committee. In a matter of a few hours, a national body of ten members of the American Medical Association was expanded into a group of forty-eight state chairmen; the larger body immediately subdivided into a committee of several thousand members, one in each county of each state in the country.

This largest committee was soon put to work gathering in the medical preparedness blanks with which you have all become so familiar in the last year. The American Medical Association sent out 180,000 of these blanks, and the state and county medical preparedness committee members were asked to follow up on this huge mailing. The California Medical Association late last year mailed a second set of these blanks to all California physicians who had not responded to the first call.

Early this year the California Medical Association again mailed blanks to those on the list of nonfilers. Here the services of the Woman's Auxiliary were called upon, and I am particularly gratified to report to you that the ladies went right to work. They called upon physicians in person; they called them on the telephone; they wrote them personal notes in letters and postcards. In short, they got the blanks filled in and mailed to the Association's central office.

As a result of this activity, California today has a higher ranking, percentagewise, than any other large state in the Union in the number of American Medical Association blanks on file. The latest figure I have seen showed that more than 80 per cent of all physicians in the State had filed their blanks with the American Medical Association. The Association office will keep after the rest and will make

* From the office of the chairman, California Committee on Medical Preparedness.

One of the papers in a Symposium on Military Medicine, read before the Fourth General Meeting at the seventieth annual session of the California Medical Association, Del Monte, 5–8, 1941.

By Philip K. Gilman, M. D., Captain, Medical Corps, United States Navy.

up incomplete blanks in the near future for all physicians who have not to date made up and mailed in their own blanks.

Right now the American Medical Association Committee on Medical Preparedness is calling on the various states for another survey—this time to show the number of physicians who are essential to the staffs of institutions, hospitals, medical schools and other organizations, together with the number needed for the maintenance of proper health standards in industrial plants and among the civilian population. This survey is proceeding on schedule in California, and it is hoped that a complete report from this State will soon be ready.

These surveys may appear on the surface to be routine matters; however, they require a great deal of care in handling, and they call upon county, state and national committee members for quick answers to a great many questions. Our correspondence files are bulging with incoming and outgoing letters on a variety of medical preparedness matters. Our office staff is putting in a lot of time and study on this entire question.

So much for the paper work of medical preparedness. I would like now to touch on a little more tangible matter about which I am sure you will hear more later on this program from our Army and Navy representatives.

I refer to the furnishing of physicians for the armed services.

You have all become familiar in recent months with the figures on the expanded medical corps of all branches of the military service. The Selective Service Act, together with augmented enlistment campaigns, is building up a much larger Army than we have had in this country at any time since the World War. And an Army needs doctors.

I do not need to repeat to you that the Army needs more than 9,000 new physicians each year under the present program and that only 5,200 graduates are coming each year from the accredited medical schools of this country. Simple arithmetic has already shown us that close to 4,000 additional physicians are needed each year to fill up the huge gap in the Army's Medical Corps.

The California Medical Association has been asked to do its part in meeting this need, and I am happy to tell you that everything possible has been done to meet this need. Appeals have been made by mail, by publication, by personal visits and by all other available means, to the physicians of California. They have been told what is needed; they have been asked to volunteer their services; they have been shown the advantages of entering the Army Medical Corps instead of waiting for a call to other branches of the service under the draft law.

For a number of reasons, these appeals have not been very successful. But, while the appeals were being made, another situation arose which requires a lot of probing on our part and that of the Army. The anomaly has appeared in which the Army is asking for young men and is getting volunteers from the older groups. The younger men apparently are not anxious to serve, while their elders are more than anxious but are barred from service by arbitrary age limits.

Along the same line, let me mention another paradoxical situation. The Army has asked us to locate specialists for chiefs of service or assistant chiefs—but the Army expects us to find these men in the age class below thirty-six years.

One more: The Army has found that many physicians holding the rank of first lieutenant in the Medical Corps Reserve are resigning their commissions, according to their legal rights, when they are called for active duty; at the same time, the Army finds itself handicapped by law in the granting of additional commissions to qualified practitioners who stand ready to serve their tours of active duty.

I will not go into detail on these matters, but I do want to call them to your attention, so that we may all think about them. Out of our collective thinking it is likely that a sound solution to the problem will be found.

As I view the Army's medical situation today, the principal trouble seems to be one of growth. The Army has outgrown its own Medical Corps; it has outgrown the laws under which commissions have been issued in the Medical Corps Reserve; it has outgrown its own ability to expand its component departments in conformity with the demands of its entire body.

I do not like to use the expression "red tape," because it is hackneyed; however, in this case it is particularly apropos and is the best term I know of to express the only real trouble that I have been able to discover in the Army's medical problem.

May I make just a few suggestions for the possible remedy to this problem? First, let the Army advance its maximum age limit from 36 to 55 years for the granting of Reserve Corps commissions. Second, let qualified practitioners be ranked according to their professional attainments, rather than be categoried as first lieutenants, regardless of the skill they possess. Third, let those present commission holders who refuse active service be stricken from the list of reserve officers, so that their places may be made available for qualified physicians who are ready, able and willing to serve.

These suggestions are not offered in the sense of criticism of the Army or of any of its officers. Rather are they given as a means of stimulating constructive thinking toward a solution of the present dilemma.

The medical profession in California—and I have had ample opportunity to survey it in the last ten months—is ready to meet any national emergency. With coöperation on the part of federal officials, I am sure the profession's record in the present world conflict will be as glorious as it was in the days of 1917 and 1918.

1095 Market Street.

NEEDS OF THE MEDICAL DEPARTMENT OF THE NAVY*

E. U. Reed, M. D.
San Francisco

IN this symposium on military medicine, first will be sketched the opportunities for service now available in the branch of the United States Navy, which I represent.

All applicants receive careful physical examinations and a large proportion are rejected for physical defects. Waivers of the less serious defects are recommended, especially for the older and more experienced specialists and technicians, but there is no present intention to materially lower our physical requirements.

ENLISTMENTS IN HOSPITAL CORPS

Young men without special training, between the ages of 17 and 31 years, are enlisted in the Navy as Apprentice Seamen and sent to Naval Training Stations. Those who prefer Hospital Corps work, and are recommended for it, are sent to a Hospital Corps Training School for nine weeks (normally three months, but reduced during the emergency). They then go to a Naval Hospital, where their training is continued until they are considered qualified for sea duty.

Training and examinations for promotion continue throughout enlistment, and most of them become petty officers, and many of them excellent technicians in a few years.

Enlistments in the Hospital Corps of the Naval Reserve are available in all ratings and a great many are needed during this emergency expansion.

Applicants must be between 17 and 50 years old. Those who have had experience equivalent to a Junior Red Cross First Aid course, are enlisted as Hospital Apprentices, first class. Those with experience in minor surgery, or as hospital orderlies and qualified medical technicians, are eligible for the rating of Pharmacist's Mate, third class.

Enlistments as Pharmacist's Mates, second class, are limited to college graduates, qualified medical technicians, graduate male nurses and graduates in pharmacy.

Enlistments as Pharmacist's Mates, first class, and Chief Pharmacist's Mates, are limited to applicants who have had previous experience in the Hospital Corps of the Navy or the Army.

COMMISSIONS

Junior and senior medical and dental students, who are physically qualified and in good standing, are commissioned as Ensigns in Class H-V(P) of the Naval Reserve. This will permit them to complete their medical school training, unless the need for their services becomes too urgent. This opportunity is not extended to first- and second-year students, but their deferment is almost certain.

Class H-V(S) of the Naval Reserve has been established for college graduates who have specialized in subjects related to medicine. Commissions in this class are available as Ensigns, Junior Lieutenants and Lieutenants, depending on the age and number of years of experience.

A limited number of the following specialists will receive commissions in this class: Psychologists and psychophysiologists, optometrists, pharmacists, chemists, podiatrists, industrial hygienists, entomologists, malariologists, public health bacteriologists, serologists, environmental physiologists, parasitologists, helminthologists, biostatisticians and physicists.

Graduate nurses, between the ages of 22 and 28 years, are appointed as Nurses, U. S. Navy, as rapidly as they are found qualified. Nurses between the ages of 22 and 45 are eligible for appointment as Reserve Nurses.

Commissions as Lieutenants (junior grade) are available in the United States Navy, after physical and professional examinations, and between the ages of 21 and 32 years, for graduate dentists as Assistant Dental Surgeons, for medical graduates as Acting Assistant Surgeons, and for those who have also completed an internship as Assistant Surgeons.

The next examination for Assistant Surgeons will be held from October 6 to 9, at our larger Naval hospitals. That for Acting Assistant Surgeons from October 6 to 9, and that for Assistant Dental Surgeons has not been announced.

Commissions as Lieutenant (Junior grade) in the Medical and Dental Corps of the Naval Reserve for general service are available, without professional examinations, to licensed practitioners between the ages of 21 and 35 years.

Commissions for recognized specialists are available for those under fifty years old, and in the ranks of Lieutenant Commander and below, depending on age and experience.

The chief needs of the Medical Department of the Navy at the present time are for qualified medical and dental technicians in the enlisted ratings, for Doctors of Psychology, in Class H-V(S) of the Naval Reserve, for graduate nurses and for Medical Officers.

Last month there were on active duty 911 Medical Officers, United States Navy, 75 Retired Medical Officers and 514 Reserve Medical Officers, and 200 additional Reserve Medical Officers were under orders to active duty.

We needed 420 more Medical Officers, United States Navy, and 300 Acting Assistant Surgeons, to take internships in our Naval Hospitals, and then accept commissions as Regular or Reserve Medical Officers.

We also need more Reserve Medical Officers for general service, and a number of experienced specialists in pathology, roentgenology, surgery, urology, orthopedics, psychiatry, ophthalmology and otolaryngology, to complete our Naval Medical Specialist Units.

1095 Market Street.

* Read as part of a Symposium on Military Medicine at the Fourth General Meeting of the seventieth annual session of the California Medical Association, Del Monte, May 5–8, 1941.

By E. U. Reed, M. D., Captain, Medical Corps, U. S. N.; District Medical Officer, Twelfth Naval District, San Francisco.

AVIATION MEDICINE*

R. G. Davis, M. D.
Mare Island Hospital

MEDICINE has ever kept abreast of the changing times, exhibiting an unexcelled initiative and perseverance in solving the problems presented. The medical aspects of aviation in the World War have resulted in a new field of medicine. Its phases at first appeared limited to the increasing of physical standards, which decreased the accidental rate with startling suddenness; but the maintenance of flying personnel and performance demands of a rapidly growing industry, has called upon a continuous research, and today aviation medicine has become a specialty of major importance.

PRIMARY RUDIMENTS OF FLYING

The primary rudiments of flying are easily mastered by the normal individual, but the rapid progress demanded by the military in a new environment quickly challenges the adaptable margins of the human organism. A new environment produces many specialized degrees of strain in the performance of actual flight. The outstanding problems of aviation medicine are pilot selection, his maintenance, his psychophysiological characteristics, the effects of altitude, speed, vibration, noise, and resultant fatigue. Selection is based upon a searching physical examination and psychological survey of a normal individual and the medical care consists essentially in ordinary preventive and clinical medicine applied to a particular group of persons exposed to the deleterious effects and hazards peculiar to aviation. Aviation medicine, as it is known today, had its beginning during the World War, and has developed apace with heavier-than-air craft; but the physiological problems presented themselves when balloons were first used in the seventeenth and eighteenth centuries. In 1862 Glaisher and Coxwell ascended to 29,000 feet, and reported loss of visual acuity and hearing, paralysis of arms and legs, and unconsciousness.

BEGINNINGS OF AVIATION MEDICINE

The real beginning of aviation medicine was introduced by Paul Burt, a French physiologist, who began the first studies of increased and decreased barometric pressures. He was the first to discover that the principal effect of high altitude was due to decreased partial pressure. The percentage of oxygen does not vary, but the absorption is reduced as a result of the reduced partial pressure. Hence, Paul Burt, in 1875, became the father of aviation medicine and the first Flight Surgeon.

Balloons had little effect on man's desire to fly, as he wanted wings and speed. The first successful flight, in a heavier-than-air machine, was made by the Wright brothers at Kitty Hawk, North Carolina, on December 17, 1903, and this short flight marks the real beginning of the vast aeronautical industry of today.

With the exception of the recorded articles by Paul Burt and the intervening years to 1910, the medical literature contained very little relative to aviation and practically nothing of a conclusive nature. The Germans drew up minimum physical standards in 1910; and in 1915 a service for the medical control of aviators functioned regularly, so that at the beginning of the World War, the Germans were ahead of all other countries.

INFLUENCE OF WORLD WAR I

France began a similar study in 1917. At the outbreak of the World War the airplane was undeveloped, and not until 1916 was its full value recognized as a war weapon. The European expanse produced an intense interest in aviation medicine, and rapid advances were made. The first problem was selection of the pilot, as only the unfit of ground organizations, such as the infantry and artillery, were flying. As a result their life was only a matter of hours. Study of the combined allied statistics revealed that 90 per cent of all crashes were due to physical defects of the pilots; 7 per cent due to faulty material, and the remaining 3 per cent due to the enemy.

In 1916 and 1917 the physical standards were severely increased, and special psychological tests for flying adaptability began. Rapid climbing brought forth the lack of oxygen, opening up a new field of physiological research.

The end of 1917 found leading specialists supporting the air services of Germany and the Allies.

AVIATION MEDICINE IN THE UNITED STATES

Aviation medicine developed slowly in the United States; although the airplane was an American invention, it was not accepted by the War Department until 1909. The policy was keeping in touch rather than the hastening of its development. A further lack of progress of the United States advancement resulted in the three years' delay in entering the war; but the Army issued a pamphlet of physical instructions in 1908 and the Navy proclaimed similar standards in 1912. Upon our entry into the war, examining units were opened in thirty-five cities, and during the war, 100,000 applicants were examined. Medical Officers accompanied all trained units that went overseas, and the term "Flight Surgeons," was first used in 1918.

In 1919, a school for Flight Surgeons was established by the Army at Mitchell Field, Long Island. During a four months' course research was directed to oxygen at high altitudes, aerial equilibration and orientation, and reaction time tests, together with studies of the stress and strain of the circulatory, respiratory and nervous systems. From 1920 to 1926 there was little development in aviation. In 1926, the Bureau of Air Commerce was formed. In 1927, Lindbergh made his famous flight; mail contracts were let, and the Pan-American was born.

In 1930, rapid strides began in size, weight and speed of plane construction, which has continued unabated through the expansion of today.

* Read as part of a Symposium on Military Medicine at the Fourth General Meeting of the seventieth annual session of the California Medical Association, Del Monte, May 5–8, 1941.

By Robert G. Davis, Captain, Medical Corps, United States Navy, Mare Island Hospital, California.

Aviation medicine has kept apace, with groups of Army and Navy Medical Officers, trained in the Service Flight Surgeon Schools, and assigned throughout the various aviation centers.

In 1926, Major David A. Meyers of the Army Medical Corps performed the original research on blind flying, and the present day advances, which are so important in aerial navigation, have been based on his original work.

Although the medical literature became filled with scattering reports, the first textbook on Aviation Medicine was published by Bauer in 1926.

FLIGHT SURGEONS

With the Medical Officer's close association among the flying personnel, and the necessary study of physiological changes at first hand, frequent and regular flights were deemed necessary, and the term "Flight Surgeon," became universally applied.

The qualifications of a Flight Surgeon must be first, a solid foundation of medical knowledge, followed by an intense interest in aviation.

The physical examination for aviation is a searching-out process of the usual thorough examination, but revealing those physically fit plus factors essential to successful flying.

There is no mystery, but one must realize that man was not born to fly, and he enters an unnatural environment as soon as he leaves the ground.

An insurance acceptance for unlimited life insurance is not concerned with eye muscle imbalance, sluggish semicircular canals, ultra compensatory powers to ward off fatigue; as life on the ground is not subjected to the hazards of reduced oxygen, three-point landings and military aerobatics.

During the four months' instruction in the School of Aviation Medicine, an intensive postgraduate course is given in ophthalmology, otology, psychology, neuropsychiatry, physiology of altitude, investigations of the cardiovascular, respiratory and circulatory systems, instruction in traumatic surgery, and a careful summing-up survey of the selection, care and maintenance of the flying personnel. In contact with such personnel, one must establish the closest confidence and appreciation of all of their problems, both on the ground and in the air. The effects of flight must be investigated, and measures instituted to prevent any signs of early deterioration that might determine the success or failure of performance. It is preventive medicine in its highest form. Flying hygiene demands the prevention of rapidly deteriorating effects of noxious fluids and gases; nitrocellulose, dopes and paints, cleaning materials, tetraethyl in gasoline, fire-extinguishing compounds, and the nauseating effect of hot oil fumes and engine exhaust. A watchful eye must be ever alert to note the effects of wind, ventilation, cold, heat, light and the fatigue of vibration in flight, which all produce an insidious strain upon the circulatory and nervous systems. The body-weight is cancelled by a 115-mile wind. Pilot fuselage cowlings are of medical interest; ventilation of closed cabins is important, the fitting of well-ventilated goggles is required in open planes, and the effects of cold require careful clothing, as there is a two-degree centigrade change with each 1,000 feet of altitude extending to a minus 55 degree centigrade, which is fairly constant above 35,000 feet.

ANOXIA

The lack of oxygen in the blood, due to the altitude, is caused by decreased partial pressure of oxygen in the inspired air, and is not due to the mechanical effects of decreased total pressure.

From 1906 to the present time there have been a long series of scientific expeditions to various mountain peaks investigating the effects of altitude on man. These have resulted in great advances regarding the physiological adaptive processes and effects of continued residence at high altitude, but anoxia as it occurs in aviation was revealed during the World War. Planes of rapid ascent caused important medical military problems, and postwar oxygen research comprised one-half of the work done in aviation medicine. A residence at 15,000 feet is far different from the conditions presented in a plane passing in 15 minutes. We must consider the rate of ascent, duration of exposure, and frequency of exposure.*

Stevens and Anderson confirmed in their balloon ascent that the percentage composition of the atmospheric air remains practically constant up to 72,000 feet. The higher the altitude the lower the pressure. The difference in the first 1,000 feet is 27 millimeters of mercury, while between 29,000 and 30,000 feet it is 11 millimeters, and the partial pressure of each gas decreases in the same proportion. When anoxia is induced in the body, the lack of oxygen acts as a relatively weak stimulus to the respiratory center, and lung ventilation is increased. Increase of lung ventilation washes out the excessive amount of CO_2 tending toward an alkalosis and the lowered CO_2 checks the regulator of respiration. The circulatory system makes an attempt at a compensatory response to anoxia by increasing the circulation rate and thus supplying oxygen to the tissues at a more rapid rate. The altitude attained is the most important variable in

* In the gaseous exchange in the body, respiration is defined as the interchange of gases between the body tissues and atmospheric air. Normal atmospheric air is composed of oxygen 20.96 per cent, nitrogen 79 per cent, CO_2 .04 per cent. Oxygen is consumed by the body, while CO_2 is thrown off. The amount of air inspired in a normal, healthy adult is about 500 cubic centimeters per breath, but all does not reach the alveoli of the lungs, as some occupies the dead air spaces above. The portion entering the alveoli is mixed with gases already present, and is further altered, as pulmonary blood is continuously taking away oxygen and giving off CO_2. As a result, the composition of the alveoli air is 14.5 cubic centimeters oxygen, 5.5 CO_2 and 80 per cent nitrogen. The exchange of gases is dependent upon their differences in partial pressures.

Dalton's Law: In a mixture of gases each gas exerts partial pressure, equivalent to that which it would exert if it occupied the whole of the space occupied by the mixture. Dry atmospheric air at sea level and standard conditions exerts a pressure of 760 millimeters of mercury; oxygen constitutes 20.96 per cent; hence, its partial pressure $760 \times 20.96 = 159$ millimeters of mercury. Water evaporated in the lungs exerts 47 millimeters pressure, hence the alveoli gas is oxygen $750 - 47 = 713 \times .145$ per cent $=$ 103 millimeters mercury. CO_2 $760 - 47 = 713 \times .05 =$ 39 millimeters mercury. Venous blood has a lower pressure; so, by simple diffusion, oxygen passes from the alveoli to the blood, and the CO_2 passes out of the blood into the alveoli. CO_2 pressure in venous blood is about 46 millimeters. From *Aviation Medicine* by Armstrong.

aviation. Little effect is noted until 8,000 to 12,000 feet, where the oxygen supply is turned on. The maximum rate of ascent probably does not exceed 5,000 feet per minute, but it is usually 200 to 300 feet per minute in commercial aviation, and 500 to 1,000 feet in military aviation.

The effects of anoxia are accumulative at the lower rates of ascent, resulting in reduced tolerance. The more rapid the ascent, the greater the effect on the central nervous system. The slower ascent puts a greater strain on the cardiovascular system, and thus the rate of 500 feet per minute is optimum. Physical fitness reduces the effects of anoxia by direct proportion.

OXYGEN IN AVIATION

From the early experiments with crude and cumbersome apparatus, liquid oxygen, etc., present day research has all centered on oxygen in gaseous form. The pipe-stem receiver became unreliable with excessive speeds and more complicated plane maneuvers, causing sudden separations from the lip contacts, so that today, improved face masks are universally worn. They have to be carefully constructed to prevent moisture freezing, and allow use of the lips for radiophone communication. With the normal rapid changes in the body compensation above 15,000 feet, it is wise to begin using the oxygen at a lower altitude to allow a wider margin of safety. For periods of flying of two hours or longer, oxygen should be used from 12,000 to 15,000 feet, and from 10,000 to 12,000 feet when six-hour periods are ordered. Pilots at first resented the use of oxygen as they considered it reflected poor endurance, assumed it disagreeable, and were not convinced until near accidents resulted. The first reaction of oxygen failure is a feeling of well-being, just before unconsciousness results. The amount used through a visible flow meter should equal the sea level partial pressure, plus small amounts for emergencies. Gaseous oxygen is now used in commercial transcontinental liners for the support of heart ailments and prophylaxis for air sickness. Cabins for stratospheric flying are built to maintain sea level atmospheric pressures for pilot and passenger safety. Acceleration is an important phase of medical study in modern aviation. There is no physiological change so abrupt as the speed of planes from 200 to 575 miles per hour. Black-outs were common in military maneuvers, following sharp turns, resulting from the brain anemia and abdominal pooling of the blood. This problem has been solved from the hydrostatic viewpoint by the use of tight fitting belts over the pelvis and abdomen, which can be automatically inflated by CO_2 cylinders and released after severe maneuvers are ended. All accidents in aviation are carefully investigated and analyzed, listing the causative errors among the personnel, such as judgment, poor technique, disobedience of orders, carelessness or neglect and other physical failures. Power plant and structural failures, likewise receive careful analysis of their various attributes. Weather, darkness, airport or terrain conditions are accounted for, and careful graphs and general statistics are kept regarding the accident rate of hours flown per accident injury and death.

TRAINING OF FLIGHT SURGEONS

After completing the didactic course in aviation medicine, the student is qualified as an examiner, but not designated as a Flight Surgeon in the Navy until he has completed three months of practical instruction in actual flight training and allied ground school subjects, affording the student, by actual experience, the practical appreciation of flying requirements prescribed for the training of a naval aviator.

Actual flight instruction is given in primary land and seaplanes, advancing through the observation patrol, torpedo and bombing types. Solo flights are permitted in the primary seaplanes, but dual instruction carries the student through the remainder of the training, as it is not considered necessary or practicable to graduate medical military pilots.

The medical student is guided through primary and advanced acrobatics, formation flying, night flying, blind flying, beam flying, camera gunnery, dive bombing, torpedo runs and catapult launching. Intermingled with half days of flying, ground school subjects comprise the other half. Here the doctor studies radio, combustion engines, ignition, operation, together with the general upkeep and repair of power plants. In addition the course is completed with photography, aerography, including the preparation of five daily weather maps and advanced studies in special medical problems pertaining to the physical and psychological aspects of the flier. Collateral reading supports the classroom work, and while a part of the flight training and ground school hours may appear foreign to the flight surgeon, it affords him a more practical evaluation of the general aviation problems, and a direct understanding of the stress and strain on the personnel, all resulting in a greater service to the air forces of which he becomes a part.

IN CONCLUSION

The rapid strides of Germany in aviation and the background of their present war performances are adequately described by Major Al Williams, in his recent book entitled "Air Power." Although the Versailles Treaty prevented any military show of aviation, intensive laboratory research was carried on through the blueprint and small model scale stages so that the immediate factory production was underway before the Treaty was rejected. It was my privilege, in 1928, to study aviation medicine in Germany, and although a well-advanced commercial performance was exhibited, I was impressed with a possible quick transition to the military.

The training of a Navy pilot requires a year of intensive work in both flight and ground school instruction, advancing through primary land and seaplanes to observation, patrol and fighter types preparing graduates to efficiently enter the fleet organizations. Failure to satisfactorily pass the

various stages of training result in prompt removal to nonflight duties, and only those who master the meticulous requirements are awarded the coveted wings. The performance of today's Naval Air Force is not a "happenstance," and aviation medicine has kept abreast of its supportive importance.

Mare Island Hospital.

NEEDS OF THE MEDICAL CORPS OF THE ARMY*

JOHN H. SCHAEFER, M. D.
San Francisco

THE needs of the Medical Corps of the Army can be very briefly stated. The Army needs more doctors.

To understand this need, a brief review of the law under which the present training program is being conducted seems to be in order.

The law under which we are working contemplates an army of 1,400,000 men by July 1, 1941. By July 1 we will have attained that goal. The law contemplates the induction of 800,000 more men each year for one year of military training. It contemplates the release to reserve of each group upon completion of its year of training. It contemplates giving each reserve officer one year of military training. It contemplates only one year's training of the National Guard.

For an army of 1,400,000 we need about 9,100 doctors of medicine. At the present time there are approximately about 1,200 officers in the Medical Corps of the Regular Army. This leaves 7,900 medical officers to be furnished from the reserve components of the Medical Corps.

By "reserve components" is meant Officers' Reserve Corps and National Guard. As the present law contemplates only one year of training for the National Guard, we will eliminate them from this discussion.

If we are to meet the demands of the law as it now stands, we must have not less than 7,900 new Medical Reserve officers each year for the next four years at least. The medical schools of this country graduate only about 5,200 new doctors of medicine each year, and of these not more than 3,000 will be acceptable for the military service of the United States.

You have read in the press reports to the effect that Congress is contemplating raising the strength of the Army to about 2,500,000 men. If that is done we will need 16,000 doctors to take care of the Army instead of 9,100. If such an act is passed, and based upon a one-year term of service as at present, the medical profession would be called upon to furnish approximately 15,000 doctors of medicine per year to the Army.

That is a big problem.

Can you furnish us with even 7,900 doctors per year for the next five years? If so, how?

It is obvious that organized medicine cannot go to its individual members and compel them to enter the military service. It is possible, however, for you to apply the pressure of mass and individual opinion.

The *Journal of the American Medical Association* for March 1, 1941, reported that we still have 10,000 Medical Reserve Officers available. This statement is very misleading. There may still be 10,000 who have not yet been called for active duty, but of this number probably not more than 60 per cent are available in the true sense of the word. Many of these men are on the Inactive Reserve because of physical defects, which disqualify them for full duty. Many others are so near the age limit that their utilization would not be advisable. Many others have so neglected their military training as to be of doubtful value; still others hold rank earned many years ago and have allowed their professional status to deteriorate below their rank, and many more will promptly resign as soon as they are notified that it is contemplated that they will be ordered to active duty.

For some peculiar reason the older members of the profession seem anxious to serve regardless of rank or financial considerations. . . . Many of these older men uncomplainingly and apparently cheerfully give up long-established and lucrative practices and accept active duty at an actual financial loss. . . .

The attitude of the younger members of the profession is in sad contrast to that of their elders. Large numbers of those holding commissions in the Medical Reserve resign or otherwise attempt to evade service when called and it appears that those who apply for such commissions do so chiefly to avoid being inducted under the Selective Service Act. This is an alarming situation which, if not rectified, will absolutely nullify all other efforts of the profession in connection with National Defense.

It is a challenge to the profession which must be firmly and courageously met and not avoided by high sounding platitudes.

Before closing I will outline the requirements for appointment to commissions in the Medical Reserve of the Army.

1. The applicant must be a graduate of a Class A medical school. If he is a first-year intern and is from a medical school which does not grant the degree of M. D. until completion of a year's internship, he may be appointed upon certification by the dean of his school that he has fulfilled certain requirements.

2. Before being ordered to active duty he must have successfully completed a year's internship in an approved hospital and must possess a license to practice medicine in one of the states or territories of the United States.

3. He must be a citizen of the United States.

4. Regulations require, too, that he shall not have reached his thirty-fifth birthday, but recent instructions from the War Department state that the age limit will be waived for desirable applicants who have not yet reached their thirty-seventh birthday.

Care of The Surgeon, Ninth Corps Area Headquarters, Presidio, San Francisco.

* Read as part of a Symposium on Military Medicine at the Fourth General Meeting of the seventieth annual session of the California Medical Association, Del Monte, May 5–8, 1941.

By John H. Schaefer, Lieutenant Colonel, Medical Corps, United States Army.

NECESSITY OF A YARDSTICK IN SELECTIVE SERVICE EXAMINATIONS*

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Our Immediate Problem.—A discussion of many medical phases of the Selective Service problems in California would be but a tiresome review to the great majority of this audience, for, of the more than 1,800 doctors aiding in administering this work in California, over 90 per cent are members of the California Medical Association, and a considerable number of you are here. Therefore, rather than bore you with phases of organization, instruction and statistics, which we have constantly brought to you, I am confining my brief chat with you to the most important problem of the moment: that of obtaining a common level of medical interpretations.

The Medical Division, through approximately 50 or 60 recent meetings of a seminar nature, has pointed out that which, as doctors, you all are well acquainted with: As long as medicine is not an exact science, we will have differences of interpretations of the same medical facts and findings. We must anticipate rather individualistic stands by doctors, and, since this is the fact, it is not too surprising to discover that a fair percentage of selectees, presented to induction stations, considered as fit for unlimited military service by thoroughly competent doctors, are considered unfit by equally thoroughly competent doctors at the induction stations.

A study of over 2,000 California selectees turned back by the induction station medical group, as unfit, proves beyond question, that a considerable percentage would never have arrived at the station had a common level of interpretations of regulations been accepted. (Unless we point out that these rejected men have severed all home ties, sold possessions at a sacrifice, left jobs and closed businesses, only to be immediately returned, the rejections might seem of little consequence; but these are the facts.)

NEED FOR A COMMON YARDSTICK

Let me present two common subjects of disagreement between doctors: underweights and flat feet. First, underweights: Our regulations definitely tell us to accept those for general military duty (this is called Class 1-A), who are within a limit of weight as laid down in a carefully prepared table. The minimum weight is specifically laid down, although the regulation adds a line which discusses a leeway for some overweights, and does not lay down any specific limit for this. The regulation then states that certain ones may be accepted for limited military service (this is called Class 1-B), who are not within accepted weight limits. Such are those who seem otherwise mentally and physically fit. All others are to be disqualified for all military service (Class 4-F). Now, just because the regulations discuss some general conditions—which declare that allowances may be made where the weight is below the minimum, and thought correctible with food and training, and which, in view of the specific notations for Classes 1-A and 1-B, unquestionably refer to a policy of accepting some for limited service, and, possibly the rarest one for general service—some doctors insist upon presenting registrants to induction stations several pounds under the minimum weight for their height (this means about 20 pounds below standard). One doctor stated that "he knew that weight disproportion of an individual in otherwise good health, has not been considered a disqualifying factor." The very week of his statement disclosed twelve rejections at one station for "1 to 7 pounds under the minimum weight for height."

Second, flat feet: It is most apparent that the regulations mean that only very mild cases, with straight ankles and no eversion, and those without symptoms, are to be considered acceptable for general military service. Despite this, throughout the induction stations we see rejections by the score because of deformity, rigidity and weakness. The tendency is to accept civilian effort as a criterion which cannot compare to the effort of the pack-carrying soldier marching 25 miles per day.

OTHER BORDERLINE INTERPRETATIONS OR DIRECT CONFLICTS

There are many other examples of borderline interpretations, such as varicose veins or nasal occlusions, but those just presented are enough for our point. We could turn to strict conflicts with regulations, and tell of the doctor who was advised that a man having hearing in one ear of better than 5/20 could be considered as qualified for limited military service (1-B), who responded by saying: "This man's hearing in one ear is less than 5/20, he is still 4-F to me, he may be 1-B to you"; but we shall limit our problem to the borderline ones and not those of direct conflict.

"AN 'APPROVED' SOLUTION"

With our problem presented to you, what is our answer? How may we reach a level of interpretations which will bring all doctors concerned with Selective Service activities—the Examining Physicians for the Local Boards, the Medical Advisory Board physicians and the Induction Station group—to see these problems eye to eye? We feel that it is not difficult if one reviews the method of functioning of the Selective Service System. This is it: The Examining Physician of the Local Board (at times in counsel with specialists of the Medical Advisory Board) acts as a medical expert to a Superior Court (the Local Board), by presenting medical findings to that court, and, with these factative findings, he suggests a recommendation

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* Read as part of a Symposium on Military Medicine at the Fourth General Meeting of the seventieth annual session of the California Medical Association, Del Monte, May 5–8, 1941.

By Lieutenant Colonel Bert S. Thomas, M. C., U. S. A.; Chief, Medical Division, Selective Service, California.

for classification. The Local Board (the Superior Court, if you will) decides on the classification. If an appeal is taken to this decision, the Appellate Court (our Selective Service Appeal Board with a medical member) decides the appeal. The potential Trainee is then presented to the Medical Supreme Court (the Induction Station Group, if you will), and a medical decision of finality is rendered there.

Carrying the comparison further in the court structure, Superior Courts and Appeal Courts are quite certain to base their decisions on those of the Supreme Court, even though the Supreme Court judges are just other groups of lawyers as are the judges of the Superior and Appellate Courts. In a like manner, is it not logical for our boards (with their medical advisors) to take their interpretations from the interpretations of finality of the Induction Boards, even though these latter boards may only be "just other groups of doctors"? It is necessary for all doctors to seriously consider the interpretations of a single authoritative source (such as the Corps Area Surgeon) and be ready to "bend" a bit to acceptable policies which benefit all, even though there might be some ground to back up opposing thoughts which have proven unacceptable at induction stations.

The Surgeon of the Ninth Corps Area has recognized the need for a common yardstick. He has assigned a most able medical liaison officer between the Corps Area and the Induction Stations and the Selective Service System. His effort is being felt. Any apparent deviation from common policy is quickly brought into line.

GROUP EXAMINING—ANOTHER UNIFYING POSSIBILITY

We feel certain of our ground when we say that another most satisfactory method of reaching our goal is that of group examining. Doctors working in well-organized large groups are very likely to think alike. This has proven the case in many groups now operating in California. As rapidly as we can, we are organizing more groups for examining. These are especially fitted to serve in the larger communities, but such groups as the one operating in Los Gatos, for instance, proves that they may be fitted to any population. Group examining has other advantages: time is saved, conveniences (such as eliminating difficulty of appointments and interference with private practice) are gained, and, as Colonel Rowntree aptly puts it, "it removes about 50 per cent of the burden and almost 100 per cent of the drudgery."

Fortunately, at this time, we can inform you that, daily, the team is working more smoothly; and the greater reason for this is because of the splendid coöperation of your members. They are serving well, at a hard task, and we sincerely thank the California Medical Association for its wholehearted coöperation.

Suite 312, Physicians Building.

STRETCHING TEST IN NEURITIS*

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A FULLY developed polyneuritis may be easily diagnosed, but an isolated mononeuritis affecting a single sensory or mixed nerve sometimes presents considerable diagnostic difficulty. As symptoms of these not uncommon mononeuritides are often slight and unobtrusive, they are, as a rule, not recognized early. Early diagnosis is all the more important because a serious underlying condition, of which mononeuritis is only a part, may exist.

The purpose of this paper is to stress the practical value of a simple test for neuritis, which is known, but deserves more attention and elaboration. This test is based on the supposition previously formulated,[1] as follows: "To no other stimulus does a diseased nerve react so early and so markedly as to passive stretching." To such passive stretching, especially when it is done briskly, the nerve reacts with pain, which is felt in the nerve itself or in its cutaneous area.

DIFFERENT TESTS

The famous phenomenon that Lasègue found in sciatica is based on this principle. In sciatica the patient, lying horizontally on his back, experiences sharp pain when his extended leg is passively raised; bending of the raised knee causes the pain to disappear. The pain, which is due to stretching of the sciatic nerve, disappears when the nerve is relaxed. How painful this elongation of the nerve may be in sciatica is clearly shown by the fact that, in performance of the therapeutic stretching of the nerve formerly recommended in cases of adhesions, narcosis had to be administered. Neurologists unanimously agree that Lasègue's phenomenon is of great diagnostic importance. A positive Lasègue test has been found in up to 91.5 per cent of the cases of sciatica. Love and Walsh[2] found it in 82 per cent of their cases of protruded lumbar discs. Since Lasègue described his phenomenon in 1861, many modifications of his maneuver have been introduced. Some of these are: additional dorsiflexion, supination of the foot, dorsiflexion of the big toe, and adduction and inward rotation of the leg. The effect of this test on the sciatic nerve, as originally applied or of the modifications cited, has been shown by experiments which prove that the ends of the sciatic nerve may be separated as much as 3.5 to 7 centimeters.

In the sciatica test of Neri the knee on the diseased side will flex on bending the trunk with legs extended. In the test of Fajerstein, pain is produced in the diseased leg when the healthy leg is forcibly swung forward while the patient is standing. Forced bending of the head may provoke pain in the diseased leg. On arising from a recumbent position, the patient bends the knee on the diseased side to prevent painful stretching.

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Also flexing the trunk toward the healthy side causes pain in sciatica.

All these different tests for sciatica show the same mechanism: in all of them, pain is produced by stretching of the nerve.

The principle of Lasègue's test has been applied in affections of other nerves. A patient with a diseased femoral nerve experiences pain in the prone position when his knee is bent and his thigh is lifted, *i. e.*, dorsiflexed (André-Thomas, Wassermann[3]). In severe cases of brachial neuralgia, Meyer[4] found a marked exacerbation of pain in the arm when the patient assumed a "shaving" position with the head rotated and bent toward the healthy side. In all these maneuvers stretching of the nerves produces pain.

The same tenderness of the nerves when stretched can be found to an even more pronounced degree in affections involving exclusively the cutaneous nerves. These affections have not yet received the attention they deserve in the neurologic textbooks and literature. Among them we may distinguish three types. The first of these is a sensory polyneuritis which involves diffusely the sensory cutaneous nerves of the body in a more or less generalized form. This affection of the cutaneous nerves is not preliminary to a diffuse motor polyneuritis, but remains restricted to the cutaneous nerves. The works of Tchitchkina,[5] Meyer,[6] Schulze,[7] and others, have contributed, in recent years, to the recognition of this clinical entity. The second are sensory mononeuritides in which a single cutaneous nerve, purely sensory in function, is affected. The following sensory nerves may, for instance, be affected singly: the lateral cutaneous nerve of the thigh (meralgia paraesthetica), the superficial branch of the radial nerve (cheiralgia paraesthetica), the cutaneous branches of the femoral nerve (meralgia anterior), the posterior rami of the spinal nerves (notalgia paraesthetica), the sural nerve, the cutaneous branch of the obturator nerve, the saphenus nerve, the posterior cutaneous nerve of the forearm, the dorsal cutaneous branch of the ulnar nerve, and the auriculo-temporal nerve. The third is a disease that may be called "multiple sensory mononeuritis." In this condition several purely cutaneous nerves, in widely separated areas, are simultaneously or consecutively affected. The differential diagnosis from a sensory polyneuritis is, of course, sometimes difficult. The important fact is that in multiple mononeuritis the affection does not become generalized (Schlesinger,[8,9] Lazarew[10]), and the course is much milder and more protracted, being characterized by intermissions and remissions. In the light of our present knowledge and experiences we could hardly say, as Gowers[11] did in 1907, that the affection of the sensory nerves of the skin very seldom exists alone.

ETIOLOGY OF SENSORY NEURITIDES

The etiology of the sensory neuritides may be the same as that of the motor or mixed types. In the etiology of the mononeuritides, local mechanical and static conditions often play an important rôle. In many cases the etiology is obscure; in some, arteriosclerosis or some other vascular process may be held responsible. It can be said with some degree of certainty that any affection of the nutrient vessels of the nerves may produce neuritis (Schlesinger,[12] Marcus[13]). In some cases alcoholism, rheumatism, nicotine addiction, gout, or latent diabetes may possibly be considered as etiologic factors. In some of the cases I studied, no etiologic factors whatsoever could be established, even after prolonged and careful observation. But in my mind there is no doubt that some unknown general constitutional factor must have been involved. What Wilson[14] said about the etiology of neuritis of the facial nerve applies to these neuritides: "To be compelled to resort to some form of 'predisposition' (anatomical or otherwise) is unsatisfactory, but perhaps inevitable."

The symptoms of these sensory mono- or multiple neuritides are often surprisingly mild and meager. Irritative phenomena, such as pain or hyperalgesia, may be absent or very slight, and this regardless whether the limb is at rest or in motion. The points of exit of the cutaneous nerves may not be tender to pressure. In many cases the affection may have existed for a long time before the patient was aware of it. Even intelligent patients may have noted it only incidentally by discovering a small hypesthetic spot somewhere on the most distal part of an extremity. The areas affected are usually those of the volar and dorsal digital nerves of the hand and the foot, particularly of the big and small toe, and also of the sural and saphenous nerve. In these areas no motor, reflex, vascular, vasomotor, or trophic changes are found either spontaneously or after application of heat, cold or passive hyperemia. The only objective changes are circumscribed hypesthesiae or anesthesiae for touch, pain, and temperature; slight paresthesiae occur occasionally. The distribution of sensory changes never extends over the whole area supplied by the sensory nerve involved, but is spotty. In mild cases the anesthesia or hypesthesia can best be discovered by repeatedly touching the skin very lightly with the finger, as in tickling. On the toes the sensory changes are more pronounced than on the fingers.

AUTHOR'S OBSERVATIONS

In examining certain patients with this condition, I was puzzled by their statement that occasionally, and very early in the course of the disease, they had had sharp, shooting pains in the affected area which resembled neuralgic attacks. For a long time no satisfactory explanation for this peculiar phenomenon could be found. After careful study it was discovered that the pain always appeared when the patient made a sudden movement that caused stretching of the affected nerve. If the digital nerve supplying the big toe was affected, the patient always had sharp pain in the toe—for instance, when he put on his shoes hastily or when he stretched himself in bed with maximum plantar flexion of the foot. The same pain could be elicited when the examiner brought the limb briskly or even slowly into a position that stretched the affected nerve. Each time this was done the

pain was produced. The more quickly the stretching was performed the more painful it was. The sharp pain was felt in the hypesthetic area, but it subsided quickly. Occasionally the hypesthesia became more pronounced after this stretching maneuver. To produce this pain passively, the optimal position for every nerve, as well as the optimal direction for the movement of the limb, must be found if elongation is to result. A cutaneous nerve that rests on a hard layer reacts more easily and more promptly. Pain on stretching was in some cases the first signal to the patient of the presence of his nervous affection, its degree of severity paralleled the gravity of the disease, and it was the last sign to disappear. It could be demonstrated years after all other signs of the sensory neuritis had disappeared. In cases of cheiralgia paraesthetica (isolated neuritis of the superficial branch of the radial nerve), pain in the thumb on stretching could be demonstrated as long as seven years after the sensory changes had disappeared completely.

COMMENT

From a review of the cases, and considering the mildness of the clinical symptoms and signs of sensory neuritis, the impression is gained that pain on stretching of a nerve constitutes the most outstanding feature of the disease. Especially striking is the marked difference between the reaction of the nerve to stretching and its reaction to other stimuli, such as pressure. The appearance of severe pain in the anesthetic area, due to stretching of the nerve, is so striking that the so-called "anesthesia dolorosa," often observed in neuritis, may possibly be caused by sudden involuntary stretching of the affected nerve.

This test has proved helpful in the diagnosis and differential diagnosis of neuritides. The maneuver of stretching can be so arranged as to affect only one particular nerve. Thus, spinal, radicular, plexus affections can be excluded. The great value of this stretching test consists in its invariable constancy as long as there is the slightest objective sign of neuritis, and even long afterward. It is, so to speak, the "ultimum moriens." Furthermore, it is always present in every case, so that if no pain occurs on stretching the nerve, peripheral neuritis may be ruled out.

In affections of the peripheral nerves the stretching test has proved to be more valuable than the sign of Tinel, which consists of distant tingling on percussion of a locally diseased nerve. The Tinel sign is less valuable because, first, it is not always present in diffuse affections of a nerve, and secondly, in circumscribed affections the stretching test remains positive after the Tinel test has become negative.

The marked tenderness of a diseased nerve to traction as demonstrated by this test is clearly evident from the grotesque postures assumed by patients with mononeuritis in order to protect the affected nerve from stretching. Some forms of sciatic scoliosis may be explained in this way. The patient with a painful neuritis of the femoral nerve leans toward the diseased side when standing, and the patient with an occipital neuralgia inclines his head back and toward the affected side. These postures are attempts to lighten the strain on the nerve trunk. There are many other examples of these "algogenous contractures." They are protective mechanisms for maximal relaxation which often operate, so to speak, at far-advanced posts against any possible traction on the diseased nerve.

How severely stretching may affect a nerve is seen from the pathologic reaction of a *healthy* nerve to stretching. We know that in the etiology of neuritis sudden and violent stretching of a limb plays an important part. This is especially true of the brachial plexus, which is statically and mechanically located most unfavorably, and even when normal works under strong tension. Comparatively slight trauma, inflicted by a sudden violent stretching of the arm, even without consequent surgical injuries to the surface, muscles or joints, may severely damage or actually tear apart the brachial plexus. Of great practical importance are cases of brachial neuritis, in which a sudden stretching of the nerves of the brachial plexus produces long-standing, stubborn brachial neuralgias, although no motor or sensory changes may occur in the affected extremity. Collier [15] and others have reported such cases. An awkward movement of the extended arm, such as may occur in falling, a sudden downward thrust of the shoulder, vigorous tossing of heavy weights, overstrain while playing tennis and similar activities, may produce such a neuralgic neuritis of the brachial plexus. Here the pathogenic factor lies apparently not so much in the extent of the excursion of the movement as in the suddenness and speed of its performance. It is the sudden stretching that causes neuritis. What Wilson [14] has said about the pathogenesis of the birth injuries applies to other injuries of the brachial plexus as well: "Traction is a much more potent factor than compression." I have seen cases of such stretch neuritis of the brachial plexus with predominantly neuralgic, vasomotor, and vegetative phenomena, in which the further course showed that this diagnosis was more appropriate than a diagnosis of hypertrophic cervical arthritis, spinal cord lesion, or tenosynovitis, which had been made during the early course of the disease.

SUMMARY

Every diseased peripheral, mixed, or especially sensory nerve, reacts with pain to brisk, passive stretching. This is a constant, very early and very late sign of every sensory neuritis.

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POSTGRADUATE EDUCATION IN OBSTETRICS*

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OURS is an age of change. Political concepts, social distinctions, and national boundaries are in a state of turbulence and unrest. Even the very laws of physics and chemistry have not resisted the general upheaval, since the development of the cyclotron has rapidly made necessary new interpretations of what were thought to be static relationships. My father often remarked that he had lived longer than Methusela, since, during his lifetime, there had been a greater alteration in the every-day life of man than had occurred during all of the 969 years of the fabled ancient. By that standard, each year, each month, almost each day, has set a new record for longevity. Nor are these changes confined to the world about us. Within the cloistered walls of thought that comprise Medicine, there have also been rapid mutations. Throughout our long history we have noted constant developments, but, due to our conservative background, we often are slow to recognize any but the more dramatic incidents of progress. Thus the development of insulin, the discovery of the action of the sulphonamides, and the rôle of liver extract in the combating of anemia, have each received its full mede of acclaim, whereas improvements in dietetics, in the recognition of early tuberculosis and cancer, and in the reduction of maternal death rates, are notable only when contrasted with the findings of the past.

In this Section on Obstetrics of the California Medical Association, our interest is directed to changes in the field of obstetrics and gynecology. It may truly be said that all trends and worthwhile innovations sooner or later are discussed before this body. The fact remains, however, that our tendency here is to illuminate isolated facets of the gem of medical knowledge rather than to obtain a portrayal of the whole. It would seem worthwhile, then, to consider how best we may bring the entire picture before a respectable proportion of our fellow physicians, to emphasize the highlights properly, and to eradicate the flaws that have become apparent. For this purpose, systematic postgraduate education is the only logical means available.

EARLY GRADUATE TEACHING IN THE UNITED STATES

It is interesting to remember that the earliest graduate education in this country was for the purpose of giving instruction in obstetrics. William Shippen, Jr., who had studied under Smellie and William Hunter, offered to the physicians of Philadelphia a course of eleven lectures, supplemented by manikin demonstrations and "with one natural labour at least" which, in 1762, aroused the populace to violent remonstrance. At about the same time, James Lloyd of Boston, also a student of Smellie and Hunter, received pupils for the purpose of instructing them in "natural and preternatural labour." These pioneers were subjected to the criticism of both the lay public and the profession for the impropriety of their invasion of the privacy which was woman's natural right. At least one attempt was made on Shippen's life.

So slow was the acceptance of teaching by demonstration that, when James Platt White of Buffalo conducted a delivery at a clinic of the medical department of the University of Buffalo in 1850, he was assailed by the press in scathing terms, and the recriminations of the profession were heaped upon his head. He subsequently sued one of the newspapers for libel. During the trial there was testimony by some of the leading physicians of Buffalo that the exposure of the parturient woman was wholly unnecessary, either to effect delivery or to teach obstetrics, and that such an innovation as proposed by White "shocks the moral sensibilities, diminishes the moral feeling, and debases the moral man." The American Medical Association entered the controversy, and its Committee on Medical Education, after long deliberations, stated that the exposure complained of might facilitate somewhat in the protection of the perineum, but that this was not sufficient compensation for the obvious disadvantages. Doctor White lost his suit. Ultimately, in the face of these discouragements, the first obstetrical teaching clinic in America was established in Buffalo, with Doctor White as chief—some twenty-five years after his initial attempts.

Obviously, these problems of the past are not those of today. No longer is it possible to compress all the wealth of obstetrical knowledge within the confines of eleven lectures. No longer would the observation of one delivery be classed as advanced obstetrical experience. Hence it is not possible now to present a cursory discussion of elementary values that will be received with interest. For those of us in practice, the question of the moment is "from whom or from what may we learn?" For our teachers and professors, the problem is as to how best to offer material of practical value to the practitioner.

OBSTETRIC LITERATURE

We learn, of course, from many sources. New books present their messages in compact form. A recent edition of one of the several excellent ob-

* Chairman's address. Read before the Section on Obstetrics and Gynecology at the seventieth annual session of the California Medical Association, Del Monte, May 5–8, 1941.

stetrical textbooks is a necessity to anyone who occasionally supervises a delivery, but textbooks, unfortunately, are out of date practically as soon as printed. Journals, in particular the three devoted to obstetrics and gynecology, present so many articles that most of us rely upon abstracts in order to cull out the papers that we deem worthy of intensive study. For most of us, even the reading that we attempt is a difficult task, and our interest is often disturbed by the inevitable interruptions that make up the joys and headaches of practice. The printed page lacks the vitality of spoken words. Hence our enjoyment of our local and state meetings, our delight in "talking shop" whenever and wherever opportunity affords. Thus we exchange ideas, revise our modes of therapy, and seek new views of persistent problems.

TOPICS FOR DISCUSSION

Our opportunity for listening and for discussion in obstetrical matters is usually quite restricted. Except in the larger centers, one or two programs during a year are all that is available. Further discussion of the advances in our field is essential if we are to keep abreast of the times. Consider, for the moment, the topics concerning which we need the enlightenment of the newer developments. A partial list would include Caldwell and Malloy's study of the configuration of the pelvis, x-ray pelvimetry, the treatment of pyelitis with mandelic acid and sulfanilamide, episiotomy and its anatomical repair, improvement in the technique of Cesarean sections, the care of pregnancy complicated by tuberculosis, and a whole host of similar subjects. Two more, of which we learn too much from enthusiastic detail men, are the related values of minerals and vitamins in the dietary needs during pregnancy.

REFRESHER COURSES

It should be quite evident that, if we are to acquire all of this information, to be fully educated even in a limited portion of practice, we will have no time to see patients. We must, therefore, effect a compromise, and select some method whereby we may predigest much of the food for thought. Such a compromise may be found in the so-called "refresher courses" offered at postgraduate schools and university hospitals, including our own, where demonstrations and lectures are arranged to review, in two or three weeks, the problems encountered in general practice. These courses are excellent, but thus far attendance has been extremely limited. The difficulty of leaving one's practice for the necessary time, the expense involved, and possibly the realization that the financial return would be greater if the same effort were applied to some other phase of practice, have built up too much inertia for the average practitioner to overcome. Hence, the hospital courses, although of great benefit to those who can avail themselves of such facilities, fall short of meeting the needs of the majority.

IOWA PLAN: EXTRAMURAL COURSES

But "Mahomet went to the hill," as Plass aptly recalls. In 1929 the University of Iowa Medical School initiated a series of extramural lectures given wherever a sufficient group of physicians desired. The idea of transporting the classroom to the student instead of the reverse arose from a consideration of two factors. The first, that very few physicians in practice could avail themselves of the postgraduate teaching that was offered, has already been noted. The second, and possibly the more important, was that there was an insufficient number of teaching cases for the undergraduate work without diverting any of such material to graduate instruction. Incidentally, this is the case in practically all teaching hospitals. It was quite evident, then, that if postgraduate instruction was to be developed without infringing upon undergraduate prerogatives, such work would of necessity be carried afield. Accordingly, a course of twenty hours divided into ten sessions, was suggested to county medical societies, and rapidly the plan was under way. As it has developed, the county society is the typical sponsor, although county lines are not considered. A course is presented wherever physicians register in sufficient number to meet the expense involved. Attendances up to a hundred have not been infrequent, although a smaller group, fifty to sixty, is preferable. As to costs, the Iowa plan embodies a registration fee of $10 for each course. This has paid the travel and material expenses, and has also provided a small stipend to the part-time members of the itinerant faculty. An additional item to be considered is that the registration fee has served to stimulate interest and attendance, since it is only human to attempt to get full value from any expenditure.

HOW FIELD WORK WAS RECEIVED

The striking response of the Iowa physicians to this type of study awakened the interest of other departments, and shortly there were courses in surgery, medicine, and pediatrics which were enthusiastically received. Neighboring states adopted the idea, sometimes borrowing full-time instructors during the summer months, until the west central states now are a vast network of postgraduate centers. The period during which groups were urged to accept a course has long since passed, and a new problem, that of supplying an insistent demand, has arisen. The authorities in charge have realized from the beginning that the type of instruction needed was different from that in the student classroom. The practitioner is not interested in how to measure accurately the diameters of the pelvic inlet. He is concerned with the age-long problem of gauging whether this particular baby may be expected to pass through this particular pelvis. His patients are individuals, not merely members of a classification. His instructor, therefore, must be able to teach from personal experience and interpret the literature in that light.

In view of the appeal of actual demonstration, it would appear that case-teaching should be used in field work of this type. Two reasons prevent its utilization. The first is that it would be difficult to shift the arrangement of lectures to the material at hand according to whether there was available

a patient with ectopic pregnancy, eclampsia, or placenta previa. The second is the hazard of possible criticism of the attentions given the patient by the physician in charge. The suggestions given may be most helpful, but the probabilities of fanning into flame the local jealousies are too great. Moving pictures probably will supply this deficiency to a large degree.

Some years ago our State Society urged the county organizations to appoint committees on postgraduate work and outlined topics suitable for presentation. While many of the meetings so sponsored were of excellent grade, the real values oftentimes were obscured by the necessity of covering too many subjects in a short time. The usual procedure was to hold a "Postgraduate Day," and possibly six rather unrelated presentations of an hour each left the listeners paralyzed from so lengthy a session. By the time the last speaker had finished, the material presented in the first lecture was forgotten. For a balanced mental diet, too many meat courses were served, and too rapidly for adequate digestion.

Because we saw the error inherent to this indiscriminate grouping, and because we felt that a better interest in obstetrical matters would lead to better obstetrics, some half dozen of us in Los Angeles decided upon offering independently a series of talks, each of us selecting two subjects. This we began two years ago. Naturally our first efforts were somewhat inept. We had to learn by experience to condense theory interesting to select groups and to emphasize specific points in practice. In time, we may develop a definite service to our neighboring areas, provided, of course, that they can put up with us until we really are of value.

RECOMMENDATIONS

But this effort cannot measure up to the Iowa project. For one thing, we have practices to maintain, and must substitute speakers on occasion, according to the demands of our patients. For another, distances in California are great, and the outlying counties must not be forgotten. It would seem that a better coverage and by better lecturers should be possible. Specifically, I suggest that the California Medical Association authorize the payment of travel expenses of lecturers on obstetrics, at the various county centers. This would relieve the lecturer of expenses which are not properly his own, and would give every physician wherever situated a definite interest in the State Society. Next, the lecturers should be selected by the professors of obstetrics at California and Stanford in the North, assisted by the professors at Southern California and the Medical Evangelists in the South. Who better qualified to know which men to present a given subject in forceful fashion? I suggest further that such proposed lectures be arranged as a course of eight to twelve separate talks and presented as a unit. Not more than two papers should be given on any one date, separated, if possible, by the dinner hour. A session each week gives time to absorb and arrange mentally the pertinent facts given by the last speaker, and to meet the next with freshened interest. Probably the arrangement of topics could be added to the duties of the professor at our state school, provided that the next appointee possesses the driving force and organizing ability that has been the happy possession of the present incumbent. While a more unified service could be rendered were one lecturer to conduct an entire course, this is not feasible except where full-time teachers are available. None of us in practice could afford to maintain for long a schedule of one or two nights per week away from our usual haunts. A further practical objection to the one-man course is that there are few indeed who can speak entertainingly upon more than three or four subjects. Since our medical school departments are not on a full-time basis, the arrangement of a team of speakers becomes automatically the only solution available. Lastly, a small registration fee would aid in the meeting of expense accounts and insure continued interest.

IN CONCLUSION

This thought, then, I leave with you. Our annual meeting and our county sessions are not enough. Our reading, valuable as it is, lacks continuity. Detail men are more interested in the building of demand for products than in the dissemination of education. We must lift ourselves by our own bootstraps—and we have at hand bootstraps of quantity and quality.

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CUTANEOUS AND MUCOUS MEMBRANE CANCER*

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THERE always has been, and there probably always will be, great argument between dermatologists, surgeons and roentgenologists as to the "best treatment" of skin and mucous membrane cancers. It can be said without fear of contradiction that the first necessary element in this "best treatment" is skill in recognizing the clinical picture of these malignancies and, what is just as important, an equal skill in recognizing the clinical pictures of the various dermatological entities which may mimic them. There can be less certainty about the second necessary element in this "best treatment," that is, which type of therapy should be applied to any given cancer.

I have always had a strong personal preference for the destructive methods of therapy, such as electrosurgery, the actual cautery or excision, over radiation therapy. However, I have always felt that any physician who is especially interested in this field should have available to him, and should be expert in the use of, all of these modalities.

Because of the many wordy battles in which I have engaged relative to this subject, I decided a

* Chairman's address. Read before the Section on Dermatology and Syphilology at the seventieth annual session of the California Medical Association, Del Monte, May 5–8, 1941.

couple of years ago to review my cases in order to speak more accurately concerning my own results. Accordingly, in the fall of 1939, a study was begun of the cases treated in my practice and that of my partners, Doctors C. J. Lunsford and H. V. Allington. It did not include the large number of cases that have been seen and treated at the Alameda County Hospital and clinics because I felt that the results as seen in our private practice would be more representative of our efforts.

It should be admitted at the outset of this discussion that our statistics cannot compare in accuracy with those of institutions or groups who employ expert record clerks and statisticians for constant control of their records. Neither I nor my office secretaries are particularly skilled in this field. There are several other factors which make it difficult to attain statistical accuracy in a survey such as mine. Many of these patients, already in the older age group when treated, had died of old age or other causes before this study was begun. Others had moved in the intervening years and could not be located. But in spite of all of these difficulties I feel that my figures are a rough index of what has been accomplished in an ordinary private practice.

Up to date my partners and I have seen approximately 2,000 cases of skin and mucous membrane cancer. Of these, 1,502 were seen up to 1939 and are included in this study. The sexes were about equally represented in the 1,502 cases. No particular study was made of the age distribution, but it can be stated that most of the cases occurred in the group past middle life, as would be expected. The great majority of lesions were found on the face and neck, 76 per cent. Seven per cent were located on the lower lip.

As many of the patients were seen in consultation for other physicians, and as some did not accept our advice as to treatment, the total number of those treated and subsequently included in this study is 1,281.

BIOPSIES

Biopsy specimens were taken from 262 of the 1,281 treated cases, roughly 20 per cent. Our policy in regard to biopsies is to omit them when the lesion is typically epitheliomatous in appearance. Most of the patients in this series were checked by all three members of our group. When there was any disagreement or when the lesion was atypical, a biopsy was done. I believe this policy is a safe, practical one in the hands of physicians experienced in this kind of work. Less scarring results in those cases in which a biopsy is not needed. I recently personally interviewed a large number of the leading dermatologists of the United States and found that the great majority of them followed a biopsy policy similar to ours. It should be emphasized that when there is any doubt as to the clinical diagnosis a biopsy must be done.

About half of the biopsies from lesions of the glabrous skin were squamous cell epitheliomas and half were basal cell epitheliomas. A few belonged to the "mixed" group of basal-squamous type, a type of microscopic picture which exists, I believe, more often than is generally stated. As would be expected, nearly all (94 per cent) of the epitheliomas of the lower lip were of the squamous cell variety with only a few of the basal cell variety. Of those seen on the upper lip, a higher percentage (33 per cent) were basal cell in type, probably because they arose from the skin at the mucocutaneous junction and spread onto the lip. All biopsies from lesions from mucous membranes other than the lips showed a squamous cell structure. Of the unusual malignancies, our series included one each of lymphosarcoma, sarcoma, pagetoid epithelioma, two examples of erythroplasia of Queyrat, three of lymphoblastoma and five melanomas.

METHODS OF TREATMENT

An analysis of the methods of treatment employed discloses our preference for destruction by electrosurgery which was used in 71 per cent of our cases. Sixteen per cent were treated by destruction followed by radiation, 7 per cent by radium alone, and 6 per cent by x-ray alone. When we treat by means of radiation, we use fairly heavy doses; for example, in treating epitheliomas of the skin, we give from 3,000 to 5,000 roentgen units of unfiltered radiation usually in a single treatment.

CANCER OF THE SKIN

Of 1,131 treated cutaneous epitheliomas, 91 were completely lost track of and are not included in our results. Of the balance, 98.7 per cent were classified as "cured" and 1.3 per cent as known failures. A breakdown of the "cured" cases shows that 47 per cent of them were well when last seen less than two years after treatment, 31 per cent between two and five years after treatment, and 22 per cent were well five years or more after treatment.

CANCER OF THE LOWER LIP

One hundred and ten men, and three women had cancer of the lower lip without glandular involvement. One hundred and two were treated, but ten were lost track of and were not included in this study. Of the ninety-two cases studied three are known to be failures and eighty-nine are "cured"—forty-two for one to two years, thirty-two for two to five years, and fourteen over five years.

When treating lip cancer we rely mainly upon destruction by electrodesiccation or electrocoagulation. Forty-six of our patients were treated by these methods. Earlier in our experience we followed destruction by heavy doses of x-ray (47 patients in this series), but in recent years I have been omitting the x-ray, as I am certain that the percentage of cures is just as high without it and that the cosmetic results are far better when it has not been used. Three of our patients were treated by x-ray alone, and six by radium alone. None of these lip cases had glandular involvement, and in none of them was filtered x-ray given to the gland-bearing area of the neck.

CANCER OF THE UPPER LIP

An interesting finding in the series of upper lip cases is the high incidence (72 per cent) in women. Thirty-one cases were treated and all were finally classified as "cured"—eleven less than two years, fourteen between two and five years, and six over five years. Eighteen were treated by destruction alone, eight by destruction plus radiation, four by radium and one by x-ray.

All of our cancers of the lip, either upper or lower, are treated in the office, hospitalization being unnecessary. If the lesion is of the usual size, it is blocked off by procain. In a few instances of extensive involvement of the lower lip I have used double mandibular nerve block.

CANCER OF THE ORAL CAVITY

Forty-seven patients were seen with cancer of the tongue or oral cavity. Thirty-five of them were treated by us. Our main weapon in these cases was extensive electrocoagulation, but we often supplemented it with implants of radium seeds or deep roentgen therapy. Of twenty-nine patients who presented no glandular involvement at the time of operation, three were lost track of, seven are known to have died of the disease, and nineteen are tentatively classified as "cured." Of these nineteen, six have been well for less than two years, eight from two to five years, and five have been well over five years. Six patients were treated by us with advanced cancer of the oral cavity showing extension to the glands of the neck. All of them died in spite of treatment, which generally consisted of destruction, plus radium implants, plus deep roentgen therapy. As I look back upon this group I sometimes wonder, but generally doubt, whether or not extensive neck dissections would have improved our results.

OUR OWN RECURRENCES

A study of our own thirty-seven recurrences has been of particular interest to me. Recurrences were seen in 18 per cent of the patients whom we treated by radiation (10 per cent radium and 8 per cent x-ray), in 2 per cent of those whom we treated by destruction, and in 2 per cent of those treated by destruction plus radiation. This would indicate to me that in our hands the destructive forms of treatment are far less apt to be followed by recurrences than when radiation is used. It also shows that the percentage of recurrences is not lowered by using radiation after thorough destruction. Five of our thirty-seven patients with recurrences refused further treatment, one was lost track of, two died from the disease, two were cured by other physicians, two were cured by our x-ray and twenty-five were cured by us by destruction.

RECURRENCES AFTER TREATMENT BY OTHERS

Thirty-four patients came to us because of cancers which had recurred following treatment by other physicians. Nineteen of them had been originally treated with radium, eight by x-ray, one by carbon dioxid snow, one by curettage, one by electrodesiccation and three by methods unknown. Twenty-nine of these recurrences were treated by us—twenty-one by destruction, three by radium, one by x-ray and four by destruction plus radiation. Two of these patients died, one was lost track of and twenty-six are considered cured.

The death rate among 1,281 patients treated by us was 2 per cent. As would be expected, the highest percentage of the deaths occurred in our mouth and tongue cases.

SCARRING

When I originally undertook this study I had hoped to be able to find out how satisfactory or unsatisfactory were the scars which resulted from destructive forms of therapy, and to be able to compare them with scars resulting from radiation therapy. It has always been my impression that although the scarring immediately following destructive forms of therapy is worse than that following radiation therapy, in the long run the scars following destruction are less objectionable. Scars from destruction therapy improve with time, while those from heavy radiation therapy may become worse, may become atrophic, telangiectatic and may degenerate into radiation malignancies. However, my figures are too inconclusive to settle this question. Too often our case records failed to say much about the cosmetic character of the scar, and too often in the questionnaires would the patient say the scar was satisfactory in view of the seriousness of the condition. Parenthetically, it may be of some interest to note that after the seriousness of skin cancer has been explained to these patients of the upper age group, they are perfectly willing to accept the danger of scarring.

Of 367 case histories which accurately described the scar at the end of treatment, twenty of the scars seemed conspicuous to me. But of the same series, only ten (3 per cent) of 289 patients who answered the questionnaire, said that the scars were objectionable.

COMMENT

The results as given above are those obtained in consecutive unselected cases of skin and mucous membrane cancer seen in our private practice of dermatology. Although destruction by means of electrodesiccation, electrocoagulation or the actual cautery was the favored method of treatment, heavy doses of unfiltered x-ray or appropriate doses of radium were available and were given when we considered them indicated.

The results that we obtained are, I believe, roughly the same as those of dermatologists throughout the country.

I feel that the diagnosis and treatment of these purely ectodermal tumors lie particularly in the field of dermatology. Not only is the dermatologist best equipped to deal with their differential diagnosis, but also he is thoroughly trained to use, and has available, all of the modalities necessary in their treatment.

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NEOPLASMS OF THE RETICULO-ENDOTHELIAL TISSUES*

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INTRODUCTION.—The clinical manifestations of reticulo-endothelial neoplasia are so highly variable that there might seem to be little correlation between the various morbid processes. This is far from being the true condition, however, as will be presented in the following summary. The essential differences in this group of neoplasms are determined by the wide distribution of normal reticulum cells throughout the body and their ability to form a mobile tissue. These features account for dissemination or circulation of neoplastic cells in a way totally different from ordinary cancer.

The effects of intoxication, infection, granulomatous conditions, and defective metabolism on proliferations of this tissue are well recognized. Reticulo-endothelial tissues are characterized by their ability to respond to these stimuli and sometimes pure reactionary hyperplasia assumes almost neoplastic proportions in its intensity. There may be, therefore, uncertainty regarding the status of some processes which are now considered neoplastic, and it is possible that future study may demonstrate a specific etiology for some.

An arbitrary point of view might be assumed, and proliferations of reticulo-endothelial tissues unrelated to known causes or specific etiology are considered to be neoplastic. Proliferative processes limited topographically to the reticulo-endothelial system of the body are designated as reticulocytoma. When the neoplastic proliferations penetrate the barriers of the reticulo-endothelial system and other tissues are involved, frank malignancy is assumed, and the process is regarded as reticulum cell sarcoma.

PATHOLOGY

The morphology of the neoplastic reticulum cell is highly variable. Its name is derived from the fact that it is capable of forming fine intercellular silver positive reticular fibrils, which may be demonstrated by appropriate methods. Reticulum cells do not necessarily represent an end-stage of differentiation, but are capable of developing into fibroblasts or cells of lymphoid tissue; and one may find, therefore, similar transition stages in the neoplastic proliferation. They are also capable of forming leukocytes of the blood, and the end-product of this differentiation may be a cell similar to the monocyte derived from myloid tissue.

Final morphological identification of the reticulocytic neoplasm is based upon the observation of sheets of mononuclear cells of medium to large size, sometimes with multiple nuclei; evidence of motility; indented and lobulated nuclei; and ability to form reticulum. Neoplasia may be expected in any location of the body normally inhabited by these cells. The proliferation may be focal or generalized and the blood may or may not reflect the proliferative process. The clinical manifestations of such neoplasia, therefore, will be variable and will be discussed in regard to the systems affected.

CLINICAL MANIFESTATIONS

1. *Effect Upon the Blood:*

The concentration of any of the formed elements in the circulation may be altered.

(a) *Leukocytes.* Leukopenia is observed either as a result of extensive bone marrow involvement by the neoplastic process itself or from generalized bone marrow depression associated with splenomegaly (Banti's syndrome). In the former instance, abnormal cells may be found in the blood-smear, even though the total count is greatly reduced.

Leukemia may result from reticulocytoma when the process affects bone marrow. The end-products of cellular differentiation in this instance may be the monocyte (Schilling type of monocytic leukemia). It is of interest that in myelocytic neoplasia, the monocyte may also be the end-product of cellular differentiation (Naegli type of monocytic leukemia), and that this blood cell may be formed by neoplasia of either tissue. The prognosis is very poor in all cases in which the reticulo-endothelial cells and their products of differentiation occur in the blood.

(b) *Erythrocytes.* With extensive bone marrow destruction by reticulocytoma, anemia of a secondary type may become marked. The appearance is sometimes that of an aplastic type, and the true condition is not recognized until the time of post-mortem examination. Anemia may also appear without apparent bone marrow involvement where there is marked splenic enlargement.

(c) *Platelets.* Thrombopenia may be associated with the anemia and leukopenia in localized reticulocytoma of the spleen; all formed elements returning to a more normal level after splenectomy. Diminished numbers of platelets also occur in some cases of advanced bone marrow disease, and purpura may become an outstanding feature of the clinical course.

Increased numbers of platelets are sometimes noted. Extramedullary development of megakaryocytes from local reticulocytoma has been described, and the term megakaryocytoma has often been suggested for certain forms. In rare cases thrombocythemia has been observed.

2. *Effect Upon Bone:*

It is apparent that this change is secondary, and due to the presence of tumor masses in the bone marrow which produce pressure erosion. Sarcomatous forms may invade even the extra osseous soft tissues.

(a) Certain instances of reticulocytoma seem to begin in a single focus and grow as malignant tumors from that site. Bones that have been affected in this way include the long bones of the extremities as well as the bones of the pelvis, spine, and skull. This focal involvement constitutes a definite entity of primary bone tumor which has often been mistaken for Ewing's tumor or osteo-

* Chairman's address. Read before the Section on Pathology and Bacteriology at the seventieth annual session of the California Medical Association, Del Monte, May 5–8, 1941.

lytic sarcoma. Radiosensitivity and curability have been a prominent feature.

(b) Diffuse or widespread bone involvement may develop early in the course of the disease or multiple bone lesions may appear consecutively. The lesions are characterized by nodule formation with punched-out bony defects. In large lesions pathologic fracture and collapse of vertebrae often result. The process is sometimes limited entirely to bone, with progressive destruction as in plasma cell tumors, and constitutes a reticulum cell type of myeloma.

(c) The bone lesions at other times are only part of a general body disease, but do not differ in their essential nature from the above description.

3. *Effect Upon Lymphnodes:*

The clinical appearance and course may resemble lymphocytoma, and the name "reticulum cell type of lymphosarcoma" has often been used. The differentiation between reticulocytoma and lymphocytoma is based entirely upon microscopic features, but there is a definite distinction and it would seem best therefore not to combine the two processes into one group. Reticulocytoma would seem to be much more common than lymphocytoma.

The clinical manifestations are due to lymphadenopathy, which may be regional or generalized, and the nodes may sometimes gain a very large size. The rate of progress varies greatly in different individuals and no typical course can be described. The lesions are radiosensitive although in some cases growth is so active and widespread that it is not possible to effect palliation. Microscopically the structure is typical of a reticulum cell neoplasm, and does not differ from the bone or spleen lesions.

At times reticulocytoma is associated with a pronounced proliferation of lymphocytes. This combined microscopic picture presents a transition to the structure noted in Hodgkin's disease. In the final analysis Hodgkin's disease may be a specialized form of reticulocytoma associated with lymphocytic proliferation and susceptible to retrograde changes with eosinophilia and fibrosis. In the sarcomatous forms of Hodgkin's disease their reticulum cell nature is very apparent.

4. *Effect Upon Other Reticulo-Endothelial Tissues:*

The local proliferations may involve other organs of the body as tonsils, stomach, intestine and spleen, and the manifestations may be those of a primary tumor of that area.

5. *Secondary Effects of Growth:*

Secondary effects of growth may be manifested by a variety of symptoms, as fever, purpura, pain, anemia, and nausea.

REPORTS OF CASES

The following clinical abstracts of six cases of reticulocytoma are presented to demonstrate some of those features described above. In five instances the pathologic material has been recorded with the Lymphatic Tumor Registry, and the accession numbers are given.

* * *

Case 1.—A white female, 52 years of age, noted swelling of the abdomen in November, 1932. This was progressive until January, 1935, when the mass eventually filled the left abdomen. At operation on January 16, 1935, a spleen weighing 2,100 grams was removed. Four months later, a well-developed leukemic blood picture was noted, and progressive involvement of abdominal lymphnodes with ascites and anemia resulted in death in May, 1935.

Hematologic Data

Date	RBC	WBC	P	L	E	M
January 14, 1935	4.0	7,300	53	27	12	0
January 27, 1935	3.8	15,600	70	10	0	12
April 24, 1935	4.4	35,000	17	0	0	83

Pathology: Diffuse reticulocytoma of spleen. Blood changes terminally were typical of monocytic leukemia. (Lymphatic Tumor Registry, No. 491.)

* * *

Case 2.—During the spring of 1940, a 22-year-old white male noted pain in the shoulder with slight disability. In August he suffered a pathologic fracture of the upper end of the humerus and the roentgenographic study demonstrated extensive bone destruction with soft tissue tumefaction. Irradiation was instituted following biopsy of the lesion and complete healing of the fracture with disappearance of the tumor has resulted. In April, 1941, the function of the arm is over 80 per cent normal and there is no further evidence of disease. Pathology: Reticulum cell sarcoma.*

* * *

Case 3.—In June of 1935, a 21-year-old white female had severe back pain and during July experienced a "snap" in the back on three different occasions. August and September were characterized by nausea and vomiting, and progressive anemia which did not respond to adequate treatment. Several transfusions were required. The marked pain continued through the year. Roentgenograms in January, 1938, demonstrated multiple punched-out bony defects of the pelvis, spine, femurs and skull. There were three collapsed vertebrae. The anemia and pain were progressive to death in May, 1936. Pathology: Biopsies of the sternum and femur showed diffuse reticulocytoma of bone marrow. (Lymphatic Tumor Registry, No. 600.)

* * *

Case 4.—Stomach distress with full feeling was noted in May, 1936, by a 43-year-old female. By October, 1936, there was marked increase in the gastric distress, decrease in free acid and roentgenographic evidence of an organic stomach lesion. Exploration, November, 1936, demonstrated an inoperable gastric malignancy with local lymphnode metastases. Irradiation was instituted from November, 1936, to May, 1937. Recovery has been complete with no further treatment necessary. General subsequent roentgenographic examinations of the stomach show a normal organ. Pathology of biopsy: Reticulum cell sarcoma of stomach. (Lymphatic Tumor Registry, No. 677.)

* * *

Case 5.—From 1930 to 1932 a 36-year-old female noted gradual swelling of the abdomen and increasing pallor. In July, 1932, the hemoglobin was 40 per cent and the leukocyte count, 4,200. August, 1932, an 1,800 gram spleen was removed. Blood counts have been normal since this time. In January, 1937, pain was experienced in the dorsal spine and by June there was weakness in the legs. Numbness appeared in October, and in January, 1938, paraplegia with spastic gait and sensory impairment below the seventh dorsal segment had developed. Extensive peridural tumor tissue was found at laminectomy February 3, 1938, and the area was subsequently treated with x-ray during 1938. There has been full recovery from the paraylsis with no subjective or objective evidence of disease in March, 1941. Pathology: The surgically removed spleen showed diffuse reticulocytoma. The spinal biopsy revealed metastatic reticulum cell sarcoma. (Lymphatic Tumor Registry, No. 735.)

* * *

Case 6.—In the spring of 1927, a 44-year-old male suffered severely from headaches and several nodules appeared in the scalp. X-ray therapy was instituted with prompt

* Presented at the 1941 Spring Slide Conference of the Cancer Commission of California.

relief. During November, 1927, there was severe pain in the left hip and evidence of bone destruction in the left femur, left ilium and skull. Enlarged lymphnodes were found in the neck. All these lesions disappeared with x-ray treatment and the bones healed completely. In July, 1932, an enlarged spleen was discovered, which was treated with x-ray and the enlargement rapidly disappeared. In November, 1933, there was partial obstruction of the colon and at the same time a left lung tumor was discovered. Rapid disappearance followed x-ray therapy. In April, 1934, nodules appeared in the right lobe of the thyroid, and again treatment gave prompt relief. On March 24, 1935, the patient died suddenly of gastric hemorrhage. Pathology: Biopsy of cervical lymphnode in 1927 showed reticulocytoma. Postmortem examination revealed reticulum cell sarcoma of the spleen and stomach, with rupture of the splenic artery into the stomach. The bone lesions were healed. No thyroid or lung tumors were found. (Lymphatic Tumor Registry, No. 510.)

SUMMARY AND CONCLUSIONS

From the extremely varied clinical features demonstrated, it becomes apparent how fractions of the study of this disease may become split off as distinct entities by the different types of medical specialists. Monocytic leukemia is a blood disease to the hemotologist. His problems concern differentiation of leukemoid and leukemic reactions and the identification of the leukemic cells. Recognition of the cause of an anemia, purpura, enlarged spleen, or fever may be the internist's problem. The general surgeon finds a "tumor" to be removed especially in the more localized forms of reticulocytoma affecting the lymphnodes, gastro-intestinal tract, or in the splenic forms producing Banti's syndrome. Solitary bone lesions present the roentgenologist and the orthopedic surgeon with another variety of primary bone tumor. The therapeutic radiologist is delighted with the prompt response of more localized aleukemic forms of the disease which can almost be recognized by the "therapeutic test of irradiation." The pathologist has his problems in recognizing cell types and differentiating lymphocytoma, reticulocytoma and Hodgkin's disease. He finds little fundamental difference whether or not a leukemic blood picture existed.

Thus each specialist has his own interests in the problem. Pooling of the information from all sources is required to build up the complete concept of the single disease process that manifests itself clinically in so many ways. As an aid to future study and establishing a mutual understanding of this group of conditions, the following classification is suggested as a method of cataloging instances of reticulum-cell proliferation:

Proliferations of Reticulo-Endothelial Tissue

1. Irritative Hyperplasia—Etiologic Factors Known
   Reticulocytosis, histiocytosis, monocytosis
2. Proliferations Limited to Reticulo-Endothelial System —Etiology Unknown
   Reticulocytoma
   a. Leukemic
   b. Aleukemic
      1. Local
      2. General
3. Proliferations with Invasion
   Reticulum cell sarcoma
   a. Local
   b. General
4. Reticulocytoma Associated with Lymphocytoma
   Hodgkin's disease.

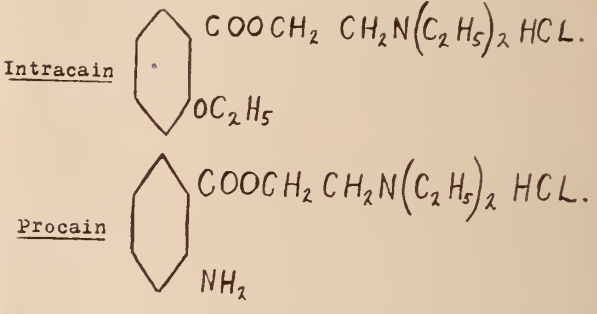
1407 South Hope Street.

REGIONAL ANESTHESIA WITH INTRACAIN*

CHARLES F. McCUSKEY, M. D.
Glendale

McINTYRE and Sievers [1] conducted experiments on a series of twenty-four drugs in an attempt to fix their usefulness as regional and spinal anesthetic agents. The criteria established for a drug to qualify for clinical trial were: (1) the anesthetic index; (2) toxicity and manner of death from an overdose, i. e., whether respiratory or cardiac; (3) ability of the barbituric acid compounds to reduce toxicity; (4) solubility and stability of solutions; (5) effects upon the tissues. One of this group, beta dethylamino-ethyl paraethoxy benzoate hydrochlorid (intracain), fulfilled these requirements and has been given clinical trial.

The difference in the two compounds is that the amino group in the para position on the benzene nucleus of procain is replaced by an alkoxy radical.



TOXICITY

The minimal lethal dose of procain subcutaneously in mice is 800 milligrams per kilo. For intracain it is 565 milligrams per kilo. Using cocain as a standard of comparison with a toxicity of one, the toxicity of procain is one-fourth, intracain, one-third, and metycain, three-fourths. Either intracain or procain produces respiratory paralysis ahead of cardiac failure, when an overdose is administered.

McIntyre and Sievers [2] have demonstrated that the barbituric acid derivatives increase the intravenous lethal dose of intracain 6.7 times, as compared to 2.7 times for procain hydrochlorid. This is a definite factor of safety in favor of intracain. While intracain is slightly more toxic than procain, the difference is so slight that we have not hesitated to use it in the same amounts as procain when necessary.

Early in this series of cases, weaker solutions were tried, using 0.5 per cent for sacral blocks, and 1 per cent for brachials. The results with these solutions were not as good as when 1 and 2 per cent procain solutions were used.[3] For the remainder of the series, 1 per cent was used for transsacral block and 2 per cent for brachials.

Epinephrin, 6 minims per 100 cubic centimeters of 1 per cent solution and 200 cubic centimeters of

* Chairman's address. Read before the Section on Anesthesiology at the seventieth annual session of the California Medical Association, Del Monte, May 5–8, 1941.

0.5 per cent solution was used in all cases, except where contra-indicated by thyroid or severe cardiac disease. The onset of anesthesia in all cases was rapid. The duration of anesthesia in those cases in which epinephrin was omitted, averaged about 90 minutes. Transsacral block, using 1 per cent intracain with epinephrin, produced anesthesia lasting three hours.[4]

In a series of 250 regional blocks, in which intracain was the anesthetic agent, the results have been excellent. Some 200 of these were transsacral blocks done for rectal operations, perineal prostatectomies, transurethral resections, etc. One of this group was combined with pentothal sodium because the patient insisted on being asleep.

Eleven were brachial blocks. Two, in which 1 per cent solution was used, were not complete, and one of these was supplemented with pentothal sodium, the other by local infiltration. The remainder, using 2 per cent solution, had satisfactory anesthesia which lasted, in all cases tested, over two hours. One patient had anesthesia at the completion of a three-hour operation.

Seven stellate ganglion blocks were done on a boy with a comminuted fracture of the arm, with circulatory disturbance. After each block the circulation improved. The injections were repeated every other day, until he was able to get along without them.

One per cent intracain was used for blocking the lumbar sympathetics in eight cases of acute postoperative thrombophlebitis. Pain relief was obtained in all cases, and marked reduction of the swelling and fever usually occurred within eighteen hours. In our experience, this procedure has given better results than any other form of treatment for thrombophlebitis.

PROCEDURES

Two technics have been used for this injection, and the results have been identical. The first is that described by Ochsner after Leriche, and consists of an injection at the level of the first to fourth lumbars. Skin wheals are raised opposite the intraspinous notch, about two fingers breadth from the midline. An 80 or 100 millimeter needle is inserted until it makes contact with the transverse process. It is then withdrawn slightly, and advanced to a depth of 4 or 5 centimeters beyond the transverse process. Ten cubic centimeters of 1 per cent intracain is then injected through each needle.

The other technic used is similar to that employed for posterior splanchnic block. A skin wheal is raised about 7 centimeters from the midline of the back, and a 120-millimeter needle inserted until contact is made with the body of the vertebrae below or anterior to the transverse process. The needle is then rotated until the bevel is toward the vertebrae. It is then withdrawn slightly, and reintroduced along the body of the vertebrae, until contact is lost with the edge of the vertebrae. The needle should not be advanced over one-half to one centimeter beyond the vertebrae. About 20 cubic centimeters of 1 per cent intracain is deposited at this point. This method is a little less painful than the multiple punctures, and equally efficacious.

Report on Cases

Sciatic and femoral block—2 per cent	1
Popliteal—2 per cent	1
Intercostal—1 per cent	1
Stellate ganglion—1 per cent	7
Lumbar sympathetics—1 per cent	8
Abdominal block—0.5 per cent	5
Peridural—2 per cent	3
Herniotomy—0.5 per cent	2
Bunions—0.5 per cent	1
Total	
Sacral block	203
Cervical block	9
Brachial block	11
Other procedures	29
	252
Untoward reactions	None
Duration anesthesia:	
1 per cent with epinephrin	3 hours
1 per cent without epinephrin	1½ to 2 hours
2 per cent with epinephrin	3 hours

ADVANTAGES OF INTRACAIN

The advantages of intracain as a regional anesthetic, which have been observed in this small series, are:

1. Onset of anesthesia is rapid.
2. Untoward reactions have not occurred following administration of 120 cubic centimeters of 1 per cent or 50 cubic centimeters of 2 per cent solution.
3. The duration of anesthesia has been twice that of procain, when used in the same strength.
4. Following rectal operations, fewer postoperative narcotics have been required for relief of pain.
5. The percentage of rectal cases requiring postoperative catheterization appears to be below average.

In comparison with other regional anesthesic agents, we have encountered no disadvantages.

In conclusion, intracain is a safe, efficient, regional anesthetic agent, which can be used for any type of regional or local infiltration anesthesia.

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WILLIAM HUNTER'S LECTURES OF 1775*

TWO RARE SAN FRANCISCO MANUSCRIPTS

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SAN FRANCISCO is fortunate in possessing two manuscripts of William Hunter's lecture notes. One is entitled, "A Treatise on Midwifery, as given by the late Dr. Wm. Hunter in his Lectures; wh a Descriptn and Representn of the Uterus and it's Contents, in the Different Stages of Pregnancy. Also the Treatment of Women in Time of

* From the Division of Physiology, University of California Medical School, Berkeley, California.

Labour &c." These notes were transcribed by an unknown auditor and have already been referred to by Dr. A. W. Meyer in this journal.[1] They begin: "The Gravid Uterus is a Subject in whh I've had better Opportunities of makg Discoveries, than perhaps any Man livg; and I flatter myself I have not Idled my Time, in my Various Pursuits on that Subject," and are to be found in the Library of the University of California Medical School. The other, "Anatomical Notes taken from a Course of Dr. Hunter's Lectures by W. D., Jan. 20th, 1775," recently came to light in the Sutro Branch of the State Library in the course of cataloguing the collection of books purchased in Europe by Adolph Sutro about 1880.

THE SUTRO MANUSCRIPT

The Sutro manuscript was at first thought to be a record of John Hunter's lectures and was so catalogued. The present identification is based upon two considerations. First, there are references in the manuscript to the lecturer as "Dr. Hunter," distinct from other brief references to "Mr. John Hunter" or "Mr. J. Hunter," who is credited with certain observations or discoveries. William Hunter, at first a member of the Corporation of Surgeons and, therefore, styled Mr., resigned from this corporation when he became a Licentiate of the College of Physicians in 1756, and from this time on bore the title, Dr.; John Hunter was always a surgeon and therefore his title was never other than Mr. Second, Mr. W. R. Le Fanu, Librarian of the Royal College of Surgeons of England, has pointed out that passages in the Sutro manuscript are exact duplicates of passages in notes now preserved in the Library of the Royal College of Surgeons which are known to have been taken of William Hunter's lectures by his students.

William Hunter has been overshadowed by his more famous and picturesque brother, but in his day William was not only London's foremost obstetrician, but also the most celebrated teacher of anatomy in all Britain. In 1768 he began to conduct his anatomical school in the new building he had just had erected on Great Windmill street close by Piccadilly Circus in the heart of London. In his plans he had included a dissecting-room, a lecture and demonstration theater, a large museum hall for the display of anatomical and pathological specimens, and, finally, as well, his own living quarters. The façade of this house, minus its original column-supported portico, is still standing, and forms the rear elevation of the Lyric Theater whose stage is actually the floor of the old demonstration theater. Since W. D.'s notes are dated January 20, 1775, they must have been taken in this building.

There are twenty-four sets of students' notes of William Hunter's lectures in the Royal College of Surgeons, London, and other sets are known to be in the Royal College of Physicians of England (also in London), in Glasgow University, and in the Royal College of Physicians, Edinburgh. Although rewritten shorthand notes of John Hunter's lectures on surgery were published in extenso in 1835 in Palmer's edition of John Hunter's complete works, only two of William's lectures on anatomy have appeared in print. These were the first two lectures of his course and they dealt with the status of anatomy from the time of the Greeks to his own day. He had prepared these two lectures with a view to publication, and before he died had actually corrected the manuscript for the press. They were published in 1784, the year after his death, under the title, "Two Introductory Lectures."

We learn from J. C. Teacher's "Catalogue of the Anatomical and Pathological Preparations of Dr. William Hunter," (1900) that the autumn course of 1775 consisted of 112 meetings, daily two-hour sessions including Saturdays and some evenings. The subject matter was distributed as follows: Two introductory lectures, eighty on anatomy, fifteen on operative surgery, three on the art of making anatomical preparations and embalming, and twelve on midwifery.

The notes in the Sutro Collection are of the spring course of this same year, but there are by no means 112 lectures. W. D. numbered the lectures up to the twenty-sixth, but at this point he became careless and the last third of these 338 pages of notes fail to show where the individual lectures began and ended. The first two lectures are similar to those William Hunter left to be published, and treat of the history of anatomy and the uses of this science to the surgeon and physician. Practical instruction begins with a discussion of blood and the circulatory system. Since it was not customary at that time to separate physiology from anatomy, discussion of function is intermingled with the details of form and structure. William allowed his brother no part in the supposed discovery that the lacteals, or lymphatics, are the sole means by which materials can be absorbed into the body—the credit for this proposition was always a source of friction between the brothers—but he does credit him with discovery of the lacteals in birds. Description of the male organs of generation, the liver, kidney, spleen, nervous system, muscles, and bones occupies in this order the rest of the first twenty-six lectures. The remaining notes are much less systematic, there are occasional repetitions and some blank pages, as if W. D. had not been too regular in his attendance and had obtained notes from some other student to fill in the lacunae. The subjects dealt with in the last third of the notes are the abdominal viscera, with special reference to the alimentary tube, again the lymphatics—including the statement that the fetus is nourished by absorption, since there is no connection between the vessels of the fetus and mother—the kidney, and finally a short section entitled, "The Physiology of Abdominal Viscera."

Although they were called anatomical, William Hunter's lectures constituted virtually a whole medical course, probably serving the note-taker as a reference book for the rest of his life.

COMMENT

Many passages in the Sutro manuscript reveal William Hunter's attitude toward current medical doctrines of his day. Chief among these was the theory that disease was the result of imbalance of the humors and, therefore, the first therapeutic measure to be employed in any disease should be bleeding the patient. It is refreshing to note that "Dr. Hunter says that he does not believe one Word about constitutional bad Humours," and as to the practice of phlebotomy, particularly to stop

hemorrhage, "Dr. Hunter thinks this method too often used." Since he was particularly interested in the lymphatics and the question of absorption, he was inclined to base his system of medical treatment on the assumption of "the Orifices of lymphatic Vessels being too bibulous and absorbing improper Things." For example, in regard to rabies he says, "In People bit by mad Dogs the Poison is not immediately absorbed." and he quotes his brother John's opinion that this is due to "Want of a sufficient Stimulus to excite Absorption and therefore he advises the Part to be cut out or eat away with Caustics as soon as possible." Again William says, "The Plague is supposed to be got by absorption alone from Contact," and he thought that venereal diseases were caused by absorption of "the venereal Poison by the Lymphatics of the Genitals." In general, therefore, he recommended that his students, "not use purges to carry off bad Humours, but Remedies adapted to faulty Absorption, viz., Bark and Sea-bathing."

A favorite diagnostic sign at that time was the appearance of a "buffy Coat" on a clot of a patient's blood, particularly if inflammation was present. William Hunter doubted the validity of this sign, since similar "Buff" could be seen in the case of pregnant women in health.

The ancient idea that "Nerves convey Sensation and incite to Motion by means of Animal Spirits"—in reality a corollary of the humoral theory—was still held by many in William Hunter's time, although some thought "Vibrations" were responsible, others "electric Effluvia." He, however, stated his conviction that we shall always remain ignorant of the cause of nerve activity since "it appears to be effected by Powers superior to mechanical ones." This is essentially a vitalistic conception of living phenomena, a conception which was not seriously challenged for another half century.

There are many references in the Sutro notes to surgical practice, one example of which may be cited. Although William Hunter was not certain as to the function of "nervous Ganglia," whether they were "muscles to press on the nerves and effect nervous Faculties, or an Appendage to the Brain to produce nervous Filiaments," he advised against opening them "since the Result will be Fever and Inflammation."

His ideas regarding personal hygiene are expressed in his advice to avoid tight-lacing, and his statement that "Varicocele may sometimes be occasioned by a too great Tightness of the Breeches Waistband." Again he says: "The best Method to prevent crooked Spines is to strengthen the Constitution, to this Effect nothing is equal to very cold Bathing; Children should be dipped and dried with coarse Cloth once a Day."

IN CONCLUSION

This brief survey of William Hunter's Anatomical notes discloses some of the reasons for his success as a teacher. He was far from being bound by tradition, and as an eminent physician was not afraid to recommend to his students a system of treatment based on his own observations and deductions. In spite of the fact that his basic theory does not stand up in the light of modern physiology, it was a distinct advance over the humoral theory of disease, especially in a prePasteurian era.

If we supplement the notes in the Sutro Collection by those on midwifery in the University of California Medical School, we have a very complete picture of William Hunter as a medical teacher in the latter half of the eighteenth century.

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BEAUTIFICATION AND IRRIGATION OF GOLDEN GATE PARK WITH A CLARIFIED, DISINFECTED SEWAGE EFFLUENT*

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FOREWORD.—Comparatively few persons, even among the medical profession, realize that the sanitary arts have been so far advanced in recent years that sewage—the spent water supply of the community, turbid, odorous, and heavily contaminated with fecal organisms—can be continuously transformed into clear water, free of pathogenes. Within the past two decades a type of sewage treatment, known as the activated sludge process, has been developed to an increasingly efficient and dependable state. Effluents from well-designed and properly operated, comprehensive plants of this sort are clear and of good appearance. They are readily amenable to disinfection with chlorin, in not excessive amounts, to the point where they will fulfill rigorous bacterial standards for drinking water.

Such a plant was constructed in Golden Gate Park about five years ago, and its effluent has been employed for irrigation and beautification purposes ever since.

A BRIEF REVIEW OF THE PROBLEM AND PROJECT

Golden Gate Park was wrested from the sand dunes of the Richmond-Sunset district in the west-central portion of the city of San Francisco and was made into one of the most beautiful and satisfactory recreation areas in the world.

Water has always been a relatively costly and, at times until very recently, none too abundant item among the City's public utilities. The long, dry seasons, with virtually no rainfall, compel irrigation. This becomes the more important and the quantitative demands greater if the soil is exceedingly porous and lacks humus. Such is the case in Golden Gate Park. Local water supplies from wells in the park area have been developed to the utmost, but have proved inadequate, particularly during long-continued periods of drought. A large park without lakes, brooks and waterfalls, in short without waterscapes, would be an anomaly: it would be sadly lacking in vital features. Such things, however, obviously demand an abundance of water.

* From the Department of Public Health, City and County of San Francisco.

Many years ago, before the residential districts contiguous to the westerly portion of the Park had become built up, raw sewage was used to irrigate certain areas by means of ditches. The inesthetic quality of this procedure, and the odors produced thereby, gave rise to serious complaints when people began to live in the vicinity. Eventually, despite the great need for irrigation water, the practice of employing raw sewage had to be abandoned.

In 1932 an activated sludge sewage treatment plant was constructed in the Park. Its nominal capacity was one million gallons per day. Since its completion, the chlorinated plant effluent has been employed for the irrigation and beautification of the westerly half of the Park area. Lakes, artificial brooks and waterfalls have been created and maintained; irrigation by means of ditches has been conducted when needful; and a limited amount of sprinkling by pressure pipe and hose has been possible, notably in the stadium.

The extraordinary, intimate extent to which the Park throughout its area is utilized for recreational purposes demands that the treatment-works operate without nuisance due to odors, or to noise (as from the blowers furnishing compressed air for the aeration of the sewage), and that the effluent be clear, nonputrescible, and hygienically safe. These results have been achieved with commendable uniformity.

GENERAL OUTLINE OF THE BEAUTIFICATION AND IRRIGATION WORKS

The works, which are involved in the beautification and irrigation of Golden Gate Park with treated or salvaged sewage, comprise: (1) a diversion chamber in the Lincoln Way sewer at Twentieth Avenue; (2) an influent or supply pipeline to the treatment plant; (3) an activated sludge sewage treatment plant; (4) delivery conduits to Metson, Elk and Mallard lakes; (5) an artificial brook with cascades and waterfalls leading from Metson Lake to the most southerly lake of Chain of Lakes, about two-thirds of a mile distant; (6) a pressure pipe-line, with hose irrigation, for the stadium; (7) and various temporary ditches for the occasional irrigation of dry wooded areas.

GOLDEN GATE PARK

Golden Gate Park embraces 1,013 acres, or nearly 1.6 square miles. It is approximately one-half mile wide, north and south, and three miles long, east and west. In addition, there is the panhandle, so-called, a parked area one block wide between Oak and Fell streets. Its length eastward from Stanyan Street to Baker Street is somewhat over three-fourths of a mile.

It would be impossible to describe the wealth of botanical material with which the Park has skillfully, but laboriously, been planted.

It is boasted, and rightly, that adequate provision has been made in the Park for almost every known sort of outdoor sport, except swimming. But swimming is adequately provided for at Fleishhacker pool, not far distant to the south.

There are upward of twenty-five miles of improved roadway and other miles of bridle-paths and trails. There are waterfalls and lakes with wild waterfowl in abundance. There are woods and spacious lawns, and gardens of flowers and shrubs, all containing contributions from every part of the globe.

It is said that the use of the street sweepings of the City in the early years furnished the humus necessary to plant life, and served to check the movement of sand by the wind.

The Park contains such famous institutions as the Museum of the Academy of Science, the de Young Museum, and the Steinhart Aquarium. There is the Beach Chalet and the Japanese Tea Garden. Here and there are wild animals: buffalo, elk, deer, bears, and many kinds of caged birds.

The Park owes its remarkable development to the distinguished Dr. John McLaren, its superintendent since 1887. He has just completed fifty years of service. It must be apparent that a great public recreation area such as Golden Gate Park can only be built upon intelligence and imagination, perseverance and hard work, money and material, fertilizer and water. All of these have been bestowed upon Golden Gate Park and have created a veritable paradise.

THE ACTIVATED SLUDGE SEWAGE TREATMENT PLANT

The activated sludge sewage treatment plant which, since 1932, has furnished its effluent for the beautification and irrigation of the westerly half of Golden Gate Park, comprises ten principal features, as follows: (1) a bar-screen and bypass structure; (2) a small control or diversion chamber; (3) two primary settling tanks; (4) two aeration chambers; (5) one secondary settling or clarification tank; (6) a chlorination contact chamber; (7) two covered sludge digestion tanks; (8) three sludge drying beds; (9) a chlorinator house, containing the one-ton chlorine cylinders and duplicate chlorin dosing mechanisms (chlorinators); (10) and a laboratory and blower house.

The plant is located on the south side of Middle Drive, about 1,000 feet westerly from its junction with the transverse roadway which crosses the Park from Nineteenth Avenue on the south to Twenty-fifth Avenue on the north.

The works have been well and artistically designed and constructed. Much attention has been given to the planting and landscaping of the site, so that it is rapidly becoming a really beautiful spot and an ornament rather than a disfigurement in the Park.

The treatment works were designed by Mr. Henry Elrod, Consulting Engineer, Houston, Texas. They were constructed by the McQueen Sewage Disposal Company under the personal direction of Mr. Frank McQueen. They were supervised by Mr. Earl Clements, Engineer and Assistant Park Superintendent, representing the Board of Park Commissioners.

The plant was built, for the most part, by "distressed" or relief labor. The cost is not known in detail, but with an additional primary settling tank constructed in 1936, it has been roughly estimated at about $85,000.

The annual cost of operation, exclusive of interest and depreciation, may perhaps reasonably be taken at about $7,500. If an allowance of 10 per cent be made to cover the fixed charges of interest

and depreciation, the total annual cost would become $16,000.

Since January, 1934, the plant has been most efficiently operated by Mr. Archie F. Fraser. In recent years he has been ably assisted by Mr. Bernard J. Boyle.

SOURCE, VOLUME, AND CHARACTER OF SEWAGE TREATED

The sewage treated by the plant is diverted from the Lincoln Way sewer at or near Twentieth Avenue. The area tributary to this point embraces about 1,350 acres and has a population of perhaps 15,000 persons. The per capita contribution of sewage ranges from a daily minimum rate of about 30 gallons to a daily maximum rate of about 100 gallons and averages perhaps 60 gallons per day. The tributary district contains two large hospitals and a restricted business section. Otherwise, the area is entirely residential. It is sewered by the so-called combined system.

At the present time the plant delivers about one-half million gallons of effluent per day, ranging in yield from a maximum rate of about 750,000 gallons per day during the forenoon hours to a low level of perhaps 130,000 gallons per day during the hours following midnight. The yield is limited by the available supply of sewage and of air, the blower capacity being inadequate for the full nominal plant output.

The dry weather flow of sewage is strong or concentrated. On Mondays and Tuesdays, particularly, it contains relatively large amounts of grease and soapy material. The average total suspended solids are in the neighborhood of 400 parts per million. The biochemical oxygen demand averages about 370 parts per million.

CHARACTER OF THE PLANT EFFLUENT

The effluent of the plant normally contains about twenty parts per million of total suspended solids, and its average biochemical oxygen demand is fifteen parts per million. The plant performance, as related to these two characteristics, has been steadily improved since the works were placed in operation. It would probably now be difficult to find anywhere an activated sludge effluent of generally better appearance and quality than that consistently produced at the Golden Gate Park plant. The plant operators should be highly commended for their excellent achievements.

The Department of Public Health of the City and County of San Francisco has assumed a degree of responsibility for the hygienic character of the plant effluent. From time to time since February 17, 1933, bacteriological samples of the chlorinated plant effluent have been collected by an inspector of the Department and have been examined in its laboratory. The visits of the inspector are irregular and unannounced. A total of 173 samples had been collected up to August 12, 1937. Total counts at 37 degrees centigrade have been made and the presumptive presence of B. coli determined in various dilutions. It has been the practice to inoculate two tubes each with 10, 1, 0.1, 0.01, and 0.001 cubic centimeters of every sample.

The results have been exceedingly good, especially during the past two years. No single sample collected in 1937 showed the presence of B. coli in any amount examined, not even in 10 cubic centimeters. During 1936, five per cent of the samples showed the presumptive presence of B. coli in one cubic centimeter and 12 per cent in 10 cubic centimeters.

The water supply of the Park, other than the sewage effluent in question, is derived from the ground. Stow Lake and other lakes supplied by ground water are generally heavily infested with algae, and are normally very green. The growth of algae is stimulated by the nitrogen in the plant effluent, so that the lakes supplied from this source are even more deeply tinged with green and are commonly turbid on this account.

USE OF PLANT EFFLUENT IN THE PARK

The effluent under discussion is being used to supply Metson Lake and the Chain of Lakes in combination with water released from Stow Lake. Elk Lake was created in 1936 and Mallard Lake in 1937. Both are supplied wholly with plant effluent.

From Metson Lake to South Lake, of the Chain of Lakes, as already indicated, an artificial brook about two-thirds of a mile in length, with numerous cascades and waterfalls, has been constructed to convey the combined flow of effluent, and of water from Stow Lake. The stadium, which can boast of one of the finest polo fields in existence, is irrigated with plant effluent conveyed in a pipe-line under pressure and applied by means of a hose, with and without sprinklers. At times and places, temporary irrigation ditches, with laterals, are employed to irrigate dry areas.

The sewage effluent is thus employed both for beautification and irrigation in the western half of Golden Gate Park, and it is difficult to separate one use from the other or determine which is the more significant.

101 Grove Street.

MEDICAL HISTORY REPEATS ITSELF

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400 B. C.

"For should you begin by discussing fees, you will suggest to the patient either that you will go away and leave him if no agreement be reached, or you will neglect him and not prescribe any immediate treatment. So one must not be anxious about fixing a fee. For I consider such a worry to be harmful to a troubled patient, particularly if the disease be acute. . . . Therefore, it is better to reproach a patient you have saved than to exhort money from those who are at death's door."

1938 A. D.

"When a long course of treatment is indicated, naming a lump-sum fee is often the best possible way to scare off the patient. Not that the amount the doctor asks is unreasonable, but the person who is going to pay it may have to be sold on the idea gradually. Many patients who shy away in alarm when you mention a charge of two or three hundred dollars can pay it, and will—if properly conditioned."

THE science of medicine had a prolonged infancy and youth, lasting from Aesculapius to Pasteur, and then grew more rapidly in fifty years than it had in five thousand. The modern scientist

is rightly proud of this progress, and it is not surprising that he has relegated to the past, and with a tolerant smile, many nostrums from the old pharmacopœias. The physician of today no longer accepts the traditions of therapy handed down by the medical fathers. One runs the risk, therefore, of being presumptious in intimating that medical science, except probably on the question of fees, is repeating its past. However, let us dare!

RÔLE OF ANIMAL KINGDOM IN THERAPEUTICS

A perusal of the annals of ancient medicine reveals that a great many of the remedies used for the cure of the sick were obtained from the animal kingdom. Sometimes the whole animal was used, more often one or more of the organs were the source of the remedy, and at times the excretions only were employed. It is recorded that the fox, boiled either dead or alive, yielded an oil which, when used as a hip bath, relieved arthritic patients of much pain and stiffness. Frogs were put to many uses before the legs alone become a delicacy. Bullfrogs were burned and the ashes used to stop hemorrhages as well as to restore hair to the bald. The meat of the frog was taken internally to counteract the effects of bites from venomous animals. Spiders were softened into a plaster and applied to the forehead and temples for headache and attacks of tertian. The slough of a serpent, when boiled with vinegar, cured toothache, and that of the asp, when triturated with honey and rubbed over the eyes, sharpened the powers of vision. Grasshoppers cured dysuria and crabs hydrophobia. Pickled sparrows dissolved kidney stones, and stewed larks cured colic. Earthworms were versatile therapeutic creatures; when pounded into a mash and applied to wounded nerves, they had a most soothing effect and, if boiled in goose grease and dropped into the ear, otitic pain was immediately relieved. If worms were stewed in oil and dropped into the opposite ear, toothache was relieved. These same worms were taken in wine to produce diuresis. The author conveniently states that earthworms might be applied internally and externally without mashing or boiling them!

The whole animal, however, is also used in modern medicine. For comparison, the following is quoted: "Ticks are permitted to feed for three days on guinea pigs, and then at once eviscerated, one by one, and ground in a mortar for ten or fifteen minutes with sterile sand and a few cubic centimeters of salt solution. The emulsion is next diluted with sufficient salt solution so that each cubic centimeter contains the equivalent of two or more ticks. The mixture is permitted to remain at room temperature for two to three days. . . The precipitate, after drying, has also been shown to possess protective qualities if remulsified and injected." In a recent journal an author states, with wounded pride, that another doctor in a treatise on the treatment of chronic osteomyelitis entirely overlooked the writer's paper in which the following statement had been made: "However, it may also be that something additional in the way of an 'enzyme-like product' is produced by the maggots' bodies themselves, which acts as a digestant and antiseptic. I suggest research in this direction. Perhaps ground sterile maggots may be shown to be useful in superficial wound infections and chronic discharging wounds and leg ulcers. A substance may be isolated from these insects that will be just as beneficial as the use of live, creeping maggots. . . . I shall not be surprised if in the not too distant future some preparation will be recommended for local use and perhaps for deep installation in the treatment of wound and bone infections; a preparation made from maggots and roaches."

EARTHWORMS AND ROACHES

Echoes of earthworms! Apparently the roaches were added as an afterthought, but what a field for research they suggest. Most people would probably prefer earthworms to maggots, even in wine. Earthworms have a pleasant association. Practically every little boy has bated his fishhook with worms dug from the dirt of his back yard, and on rainy days he has picked up the pink, lazy creatures from sidewalks to make little girls squeal and run to cover. The grown-up lad has dissected and made sections of the worms in his first biology course and learned that the inside has a structure instead of being just "mush." Maggots, on the other hand, are vile, sneaking creepers that are associated with death and decay. If popular choice were permitted, the maggots would certainly lose to earthworms.

The dangling roaches at the end of the sentence are most thought-provoking. Why not hang fleas and mosquitoes on the same line? The use of these insects in research would be such a convenient way to rid the world of undesirable pests! Furthermore, if doctors devoted more time to the study of these vermin, the pursuit might be so engrossing that cats and dogs would be given a respite. Or would this lead to an anti-flea-vivisection society? Even so, it might be a boon to the dogs to be cut in on by the fleas, for the whelps could then revert to their moral normal puppy loves.

THERAPEUTIC SPECIALIZATION

The seed of specialization was sown early. Even in the ancient pharmacopœias the use of parts rather than the whole animal for the treatment of specific conditions is found. The commonly used organs were the skin, muscles, brain, and liver, but extracts of other glands are mentioned in the records. The art of organotherapy was further specialized by the differentiation of the same glands taken from various animals. It is recorded that the skin of a sheep, warm and newly taken off, cured scourges; that of the hippopotamus, when triturated with water, dispersed boils; that of the viper promoted growth of hair. The burnt leather of old shoes cured friction sores on feet, also burns and intertrigo. The skin of the goat cured poisoned wounds.

The brain of the hare, rubbed into the gums or eaten, forwarded dentition in infants. It also proved useful for tremblings. The brain of the cock, when drunk with wine, relieved bites from venomous snakes and stopped hemorrhage from the meninges. The brain of a camel, when dried

and drunk with vinegar, cured epilepsy. The liver of a mad dog, roasted and eaten, relieved those bitten by him. Boiled goat's liver rested epileptics. The liver of the lizard relieved toothache. Equally varied benefits were accredited the livers of the ass, wolf, bear, and cormorant.

ANALOGY TO MODERN ENDOCRINOLOGY

Except for the quaintness of the language of the old manuscripts, they read not unlike the modern endocrinologies. Extract of thyroid, for instance, was originally used to treat cretins; but, according to modern papers on the subject, thyroid extract has become much more versatile: it may be used to increase or decrease fat, depending upon whether the patient is under- or overweight. Thyroid preparations have been credited with beneficial effects in as unrelated conditions as allergy and nephrosis. Extract of pituitary also has a variety of uses. It may be given to stimulate growth in dwarfism, to hasten delivery in obstetrics, to prevent postpartum hemorrhage, and to relieve obesity.

Ovarian preparations are used for menstrual disorders, but also to cure sterility and to stop bleeding in hemophilia. Extract of liver cures pernicious anemia, but it is given to any patient with a low blood count, regardless of the cause. Liver is even recommended as a general tonic for anyone who can afford to buy it, if and when it is available. The pancreas yields insulin, which is specific for diabetes, but has been advocated also for tonic purposes. If insulin is given to a "hunger striker," the patient can no more refrain from eating than Tristan and Isolde, after drinking the love potion, could resist falling in love. Even the story of a love potion is scarcely incredible any more, for the sex hormones have revived in the modern Babbit the old hope of finding a fountain of youth.

The scientist has not been content with the choice and variety of tissues supplied by the animals; he has even invaded the delivery room and gleaned its dregs to make a placental extract. This new remedy has been accredited already with such varied attributes as the cure of dysmenorrhea and the prevention of measles.

BLOOD AS A THERAPEUTIC AGENT

It would not be fair to leave the subject of animal tissues in therapeusis without mentioning blood. In the past, blood letting was a panacea for all ills; now transfusions are. In the early enthusiasm for blood therapy, doctors sometimes were too generous with the dosage. Like the new wine in old bottles, the receptacle could not always take it. Modern teachings advocate limiting the amount to 10 cubic centimeters per pound. A suggestion from Russia that the bodies of healthy accidental death victims be drained of their blood and the blood preserved for use in transfusions may develop a new type of ambulance chaser.

OTHER ORGANS AND TISSUES

It was customary, in the past, for certain tribes to drink the gall of slain warriors, believing the valor of the fallen could thus be imbibed. The modern crusader waits at the gallows to get the glands; and if ultramodern he collects the orbits, too.

Every tissue of the body has yielded its extract. Institutions have been endowed and volumes written because of glands. Nor have the possibilities been exhausted; for although the ancients failed to avail themselves of all the organs their choice of animals far exceeded ours. To be sure, scientists now use the liver of calf, sheep and chicken, and enlarge upon the comparative merits of the different ones. Even hogs' stomachs have found a place in the literature. But is it not possible that the camel, accustomed to desert tramps, may yield more insulin than the sheep or goat? That the roaring lion may supply more adrenalin than the meek lamb? A comparative study of the pituitary of the dachschund and the giraffe may illuminate dwarfism and gigantism. Likewise, a study of the hypophysis of the bulldog or the rhinoceros may give us a clue to the pathology of acromegaly. "I suggest research in this direction."

EXCRETA

Even the great variety of glands did not satisfy our forerunners; their resourcefulness found a use for excretions. Urine was used extensively by the ancients; it was especially specified that the excretion was collected from humans, mules, goats and camels, and there was some dissertation on the values of the product in various ages of the different species. When taken internally, urine cured such varied conditions as putrid ulcers, leprosy, and plague. It is described as a laxative, a diuretic, and emetic. Locally, urine preparations soothed the arthritic patient and cured erysipelas.

The dung of man and animals was found of value in many conditions. Particularly mentioned was the dung of dogs, goats, wolves, oxen, cows, sheep, wild pigeons, domestic fowls, storks, mice, and starlings. Furthermore, the excreta were modified in their uses by what the animal itself ate. Applied locally the remedy relieved the sting of wasps and bees; with vinegar it cured furuncles. If a person with dropsy had his entire body rubbed with a dung preparation, he was much relieved. This excreta was even used as a cosmetic to clear away freckles!

Not all early medical writers subscribed to the use of excretions in therapeutics. Galen rejected with disgust the internal use of urine, and another author, speaking of dung, stated: "As we have no wish to see this article restored to materia medica, we shall not enlarge upon the subject. Those who desire to improve their knowledge of the medicinal articles mentioned under this head by authors may find them treated of 'Usque ad nauseam' by Dioscorides and others."

PRESENT-DAY LITERATURE

Have modern scientists become less fastidious than Galen and his contemporaries? From the recent literature such titles as these were gathered: "Changes in eye after parenteral injection of urine and related substances lowering blood pressure," "Auto-urine therapy in spasmodic rhinitis," "Therapy of ovarian disturbances with urine from pregnant women." Even feces, which was tabooed from

the materia medica, returns to modern literature under the learned title, "Coprophogy (eating of dung) as a source of vitamin B"; and the scientist has returned to sewage for bacteriophage!

IN CONCLUSION

The repetition of the past is not limited to organotherapy; practically every drug introduced into western pharmacy has been recorded and its uses listed in the Chinese pharmacopœia. The Orientals are herbalists—animals are sacred in the East. Even the art of acupuncture is finding its counterpart in western medicine. No part of the human body—not even Achilles' heel—is invulnerable to the modern physician's needles and trocars. The child has become a veritable pin-cushion.

Even in its rapid advancement the science of medicine may repeat the past. Modern prevention and therapy are performing so many prodigies that there is danger that the followers of Aesculapius may meet the fate of their founder. The legend is that Pluto, god of hell, alarmed at the diminishing numbers of his daily arrivals, complained to the supreme deity, and Zeus destroyed the great healer. In historical repetitions some variations are permissible. The modern healers may be annihilated by the army of unfits they are saving from hell and thus complete the cycle. Verily the preacher was right when he said: "That which hath been is that which shall be; and that which hath been done is that which shall be done: and there is no new thing under the sun. Is there a thing whereof it may be said, 'See, this is new. It hath been long ago, in the ages which were before us.'"

40 Twenty-Second Avenue.

CLINICAL NOTES AND CASE REPORTS

SODIUM SULFATHIAZOLE: ITS CAUSTIC ACTION

Russell Fletcher, M. D.
San Francisco

IN the April 26, 1941, *Journal of the American Medical Association*[1] there was an article "Chronic Sinusitis," in which the use of 5 per cent sodium sulfathiazole was recommended for local treatment. Unfortunately, it was given very wide newspaper and magazine publicity. The public was told that practically all they had to do was go to a drug store and get some of this medicine and they could cure their own sinuses. The result is that many patients, general physicians, and ear, nose, and throat specialists are being requested to use this drug in the treatment of chronic as well as acute sinusitis.

The following case report indicates that the local use of sodium sulfathiazole, or in fact the use of any sodium salt of sulfanilamide may be extremely dangerous in the treatment of sinusitis.

REPORT OF CASE

A woman had a foul, purulent infection in the left antrum following a tooth extraction. There was some osteomyelitis around the tooth socket area where there was a fistula. The teeth adjacent to the fistula were loose, and the bone about the roots was involved. There was a large, loose sequestrum in the fistula. The discharge was extremely foul. The exodontist was afraid that he would stir up a more extensive process if any further operative procedure was done.

As frequent antrum irrigations did not benefit her, it was thought worth while to instill sodium sulfathiazole. Accordingly, after washing the sinuses out with normal salt solution, 5 cc. of 5 per cent sodium sulfathiazole (Squibb) was instilled. The following day the patient reported that there seemed to be less foul discharge and that she felt much better. Three days later 10 per cent sodium sulfathiazole was instilled instead of the 5 per cent used the first time. The washings seemed to be definitely clearer and were less foul. Subsequent washings were almost clear, although there were some black specks of material which were washed out. The solution came through the normal ostium of the nose, as well as out through the fistula into the mouth. During the next three weeks the sulfathiazole solution was instilled ten times. Following this, the discharge again seemed more foul and small spicules of bone were taken out of the tooth socket. The sequestrum above the fistula became more loose and it was decided that it was time to remove the two teeth next to the fistula as well as the sequestrum.

The removal of the teeth and the large sequestrum made a very large opening into the antrum which was filled with a black appearing material that had the consistency of clay. Some of this material was scooped out, and the rest of it was washed out with a syringe. No normal tissue or lining was seen. The patient made a rather uneventful convalescence.

The only variation in treatment and operation from other cases in past years was the use of the sodium sulfathiazole. Dr. M. L. Tainter of the Pharmacology Department of Stanford Medical School suggested that this condition had been caused by the excessive alkalinity of the solution employed.

COMMENT

The sodium salts of the sulfanilamide group are extremely alkaline, having a pH which ranges from 10 to 11. This is about as alkaline as arsphenamin, and it is well known that arsphenamin, because of its alkalinity, causes necrosis when it gets outside of the vein. A solution as strongly alkaline as this is extremely caustic and what happened in this antrum was simply that the sodium sulfathiazole charred or burned the granulations and entire lining of the antrum. The fact that when it was instilled each time, it ran out immediately through the nose and fistula is probably the reason more serious complications did not result, including bone destruction. There have been scattered references of the marked local irritation of tissues and mucous membranes in the literature, but these apparently have not attracted sufficient attention.

Fortunately, the chief use of this drug locally was advocated in the form of a spray which would introduce a very small amount into the nose. The protective coating of mucus over the surface of the nose has probably been sufficient to prevent this small amount of the drug causing great damage. However, I have heard of several patients who have had a very severe and unpleasant reaction when it was used this way.

The sodium salts of the sulfanilamide group are so caustic that they may do irreparable damage if they are instilled into tissues, sinuses or any body cavity such as the pleural or peritoneal cavity.

490 Post Street.

[1] Turnbull, F. M., Chronic Sinusitis, J. A. M. A., April 26, 1941, p. 1899.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should he sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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† For complete roster of officers, see advertising pages 2, 4, and 6.

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CALIFORNIA COMMITTEE ON MEDICAL PREPAREDNESS†

Symposium on Military Medicine in This Issue

Members of the California Medical Association who are interested in the status of medical preparedness should scan the papers read by representatives of the military services at the annual session held at Del Monte in May last, which appear in this issue. See pages 68, 70, 71, 74, and 75.

* * *

Few Doctors Answer Plea of Britain

Chicago, July 3 (AP).—The *American Medical Association* reported today a "not too gratifying" response so far to British appeals for American medical volunteers, and said the need for physicians at home was so great that the British request would be met "only with the greatest difficulty."

"The news from abroad and from Washington," the association's *Weekly Journal* said, "seems to indicate constantly the threat of the entrance of our own nation into the war. This also has unquestionably influenced many physicians to hesitate about answering the British appeal."

About 65 American physicians are ready to join British medical services and 25 other volunteers are likely to be available soon.

Since President Roosevelt asked the American Red Cross and medical organizations several months ago to help obtain 1,000 physicians requested by the British Red Cross, the A. M. A. has received 1,343 inquiries and sent out 643 applications.—Long Beach *Press.*

* * *

The Human Element

Dr. Thomas Parran, surgeon general of the United States, declared at a recent meeting of the *American Medical Association* it is high time the nation endeavored to make her man power as good as her machines.

Doctor Parran says there were 350,000,000 man days lost in 1940 because of illness and industrial accidents. That is equivalent to 1,000,000 men working a full year. And if 10 per cent of this loss could be prevented it would be sufficient to build five battleships or 16,407 combat tanks.

The country should not remain complacent concerning this loss of labor power at a time when national defense calls for the utilization of every bit of available skill. And

† Philip K. Gilman, M. D., 2000 Van Ness Avenue, San Francisco, is chairman of the California Committee on Medical Preparedness. Charles A. Dukes, M. D., 426 Seventeenth Street, Oakland, is a member of the American Medical Association Committee on Medical Preparedness. Roster of county chairmen on Medical Preparedness appeared in CALIFORNIA AND WESTERN MEDICINE, August, 1940, on page 86.

from the individual standpoint a day's work lost through sickness or preventable accident is gone forever.

That is reason sufficient why every man should do all in his power to guard himself against disease and practice safety. He owes it to himself and to his country to do both. —Sacramento *Bee*.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION†

PREMARITAL LAW *

An evaluation study of the Premarital Law is now being undertaken, to determine whether the law is accomplishing the purposes for which it was designed. It is a truism that social institutions which affect the intimate lives of many people, involve expenditure of substantial sums of public monies, and pertain to a major health problem, must justify their existence by demonstrably concrete evidence that definite social gains are achieved. Premarital legislation was put forward and instituted on the basis that such social benefit would be derived. The State Department of Health proposes to gather evidence which will support or refute these claims, with an impartial and open minded approach.

Again the physician is called upon to assist in the evaluation, since the survey will be based on questionnaires sent to the physician who examined the applicant for marriage certificate. The survey is strictly for statistical purposes, there being no attempt or intent to "check up" on any physician.

Of the first 200 letters sent out to physicians, 150 have been returned completed, giving data of great value to the study. This response has been most gratifying.

The practicing physician has a major interest in this legislation since it has imposed upon him a serious legal responsibility and often places him in positions where difficult decisions must be made. The physician as always is willing to take on additional burdens and responsibilities if through them his patients and society generally may benefit. He does, however, like to be certain that those benefits are forthcoming. This evaluation study should help to demonstrate the effectiveness of the Premarital Law.

COMMITTEE ON PUBLIC HEALTH EDUCATION‡

Basic Science Initiative**

Work on the Basic Science Law has started. That simple statement reads as welcome news to the members of the Committee on Public Health Education as well as to the members of the Association as a whole.

The petition forms have been printed. Letters have been prepared for mailing to all doctors of medicine and dentists in the recognized state associations. Envelopes have been addressed. Everything is ready to go.

By the time this copy of California and Western Medicine reaches you, or at most within a few days of that time, each of you will have received a letter from the Public Health League of California. A few days after you receive the letter, you will receive a printed petition form which carries the text of the proposed Basic Science Law and spaces for 100 signatures. From that point forward the success of this campaign is up to you.

It has been decided by all interested parties that the huge expense of professional petition circulating can be avoided to a great extent by the physicians and dentists of California doing their own work on the securing of signatures. If the members of the California Medical Association will do their part, this work can be completed at a minimum cost and with maximum effectiveness.

Your petition form carries a full set of instructions on the back cover. For purposes of repetition, these instructions have been printed in red ink on a separate sheet covering the face of the petition; this sheet can be torn off on a perforated line after you are familiar with the instructions.

The Committee urges each of you to read the instructions carefully. After that, your success in securing signatures will depend entirely on your own efforts. Among your friends, your patients, your office and home visitors, your neighbors, you can surely find 100 registered voters willing to sign the petition and thus help put the Basic Science Law on the ballot.

If you have any questions about the petition or the procedure required, get in touch with the San Francisco or Los Angeles office of the Public Health League of California. If you want extra petition forms for your secretary or office assistant, please ask for them. Each circulator of a petition must secure all signatures in his own presence, and nobody else can legally request even one signature for your petition.

Now that all details have been cleared, the medical and dental professions can go to work on the Basic Science Law. Success is yours for the asking.

* * *

Public Health Exhibits at County Fairs

Exhibits at Placer and Alameda County Fairs

Value of public health publicity through utilization of the facilities available at county fairs, of which there are some fifty-two held yearly in California*, was discussed in the July issue of California and Western Medicine (Pages 1 and 45), special mention being made of the results accruing from the Tehama County Fair held at Red Bluff on June 12-14.

Since then, American Medical Association and California Medical Association exhibit material has been used at the Placer County Fair held at Auburn, June 20-22, and at the Alameda County Fair, in operation at Pleasanton, July 3-12.

At the Placer County Fair, Dr. J. A. Russell of Auburn acted as chairman of the local committee handling the exhibits. For Alameda County, Dr. C. W. Mack of Livermore rendered generous service in arranging the construction of an exhibit booth, and a dark room for film presentations.

Under the new system of grants-in-aid to county fair authorities of California, it is possible during the next several years, that separate exhibit and other structures will be erected upon most of the fair grounds of the State. With such better facilities, there will be an increased attendance by visiting citizens, and greater opportunities than ever to use the fairs in the promotion of public health education.

† Component County Societies and California Medical Association members should not give endorsements to proposed legislation unless the California Medical Association Committee on Public Policy and Legislation has so requested. On such matters, address: California Medical Association Committee on Legislation, Dwight Murray, M. D., Chairman, 450 Sutter, San Francisco. Telephone, DOuglas 0062.

* From the State Department of Public Health, Bureau of Venereal Diseases.

‡ The Committee on Public Health Education was established through Substitute Resolution No. 6 at the Del Monte annual session, May 3, 1939.

The Committee on Public Health Education consists of Frank R. Makinson, chairman, Oakland; Philip K. Gilman, secretary, San Francisco; Samuel Ayres, Jr., Los Angeles; Thomas A. Card, Riverside; James F. Doughty, Tracy; Lowell S. Goin, Los Angeles; Junius B. Harris, Sacramento; Henry S. Rogers (ex officio), Petaluma. Communications to the committee may be addressed to Frank R. Makinson, M. D., chairman, Wakefield Building, Oakland, or to the California Medical Association office, 450 Sutter Street, San Francisco.

** For editorial comment in this issue, see page 56.

* For list of Fairs and dates, see July issue, page 46.

During the present year, the four American Medical Association exhibits described below are available for use through the California Medical Association.

Every component county society is urged to take up this new work. Even though the time may be short, the experience that will be acquired, if an exhibit is installed, will make for a better presentation at next year's fair. The public health exhibits have been placed in charge of the Association Secretary, Dr. George H. Kress, 450 Sutter Street, San Francisco, to whom requests for further information should be sent.

The California Medical Association will pay transportation costs of exhibits, the component county medical societies assuming the local expenses.

Descriptive paragraphs of the four American Medical Association exhibits follow:

A. M. A. EXHIBITS AVAILABLE FOR CALIFORNIA FAIRS

A. M. A. Exhibit No. 3 on "The Respiratory System of Health and Disease

An exhibit consisting of three visitor participation units showing a pair of rubber lungs and how they expand when the diaphragm is pulled down, the bronchoscope with a collection of foreign bodies found in the lungs and the nasopharyngoscope and how it is used. Several panels contain posters showing the anatomic structure of the lungs, pneumothorax, tuberculosis, silicosis, pneumonia and the common cold.

Space required, an area 10 feet wide by 6 feet deep. No tables or back walls are needed.

Electrical requirements, three outlets for lamps totaling about 200 watts.

Shipping weight, 479 pounds. (Consists of 4 gray painted cases, labeled 3a, 3b, 3c, and 3d.)

A. M. A. Exhibit No. 9 on "Dangers of Self Diagnosis and Self Medication"

An exhibit consisting of a series of transparencies in a large case 8 feet long by 4 feet high, with transparent mirror for visitor participation; two additional visitor participation units with questions and answers; three exposition files giving information on when to call the doctor, first aid and the home medicine cabinet.

Space required, area 10 feet wide by 6 feet deep (or 20 linear feet); no background necessary; strong table or horses for transparency case with two small tables for exposition files.

Electrical connections, two outlets for lamps totaling 740 watts. (Consists of 7 gray cases, labeled 9-A, 9-B, 9-C, 9-D, 9-E, 9-F, and 9-G.)

A. M. A. Exhibit No. 21 on "Heart Disease"

An exhibit consisting of panels showing the normal heart, with transparencies showing diseased hearts; an exposition file giving information about heart disease.

Space required, an area 10 feet wide by 6 feet deep; no background necessary; small table for exposition file.

Electrical connections, one outlet for lights in transparency case using 240 watts.

Shipping weight, 435 pounds. (Consists of 3 gray painted cases, labeled 21-A, 21-C, and 21-D.)

A. M. A. Exhibit No. 42 on "Patent Medicine Testimonials"

An exhibit from the Bureau of Investigation consisting of posters showing testimonials for "patent medicines" with the death notice of the person in the same copy of the newspaper, or the death certificate dated some weeks or months previously. Two visitor participation units, one with a transparent mirror showing appropriate cartoon and one with questions and answers.

Space required, a booth with back wall 10 feet wide and side walls 6 feet deep for twelve posters each 22x28 inches; two small tables for transparent mirror and question and answer device.

Electrical connections, two outlets alternating current, using about 150 watts. (Consists of 2 gray cases, labeled 42-A and 42-C.)

* * *

What Doctors Could Tell

In the Franklin *Democrat* for January 16 appears an editorial that can be read with much profit by every physician; it is but another way of putting what we have been trying to say for many years, that the medical profession is too modest about its accomplishments; too few of the American public are aware as to what we have done in years past:

American medicine, as an authority recently observed, has a weak spot. It is not a weakness affecting the patient—the sick man or woman anxiously seeking a return to health. The weakness lies in the fact that the medical profession has been so busy fighting disease in experimental laboratories as well as at the bedsides of the ill, that it has found little time to tell the public of its tremendous achievements. But an amazing story could be told.

The undeniable record is there for all who wish to read it. And it tells, through the figures, a dramatic and inspirational story of an endless battle against disease and suffering and death.

That battle has won victory after victory. In the period of a century and a half, in this country, the life expectancy of man has nearly doubled—from 35 to 62 years. During that time, typhus, once one of the greatest killers, has all but disappeared. Smallpox and diphtheria, dreaded specters not so long ago, have been robbed of their terrors.

Other great scourges, typhoid, diabetes, tuberculosis, have been put under control, and their mortality rates steadily reduced.

That is what American medicine has done. And all over the land, and in countless laboratories and institutes for the most part privately financed and managed, the doctors and the scientists are fighting, day and night, the scourges which have not yet been conquered.

Medicine is not an industry. But like industry, it has rendered its greatest service to the people under a system which places no brakes upon the achievements of the individual, and which encourages any man, in any field, to develop his talents to the utmost.

* * *

Dramatic Health

A symposium of members of the *American Medical Association* recommends that health education in schools be dramatized so that children wil take a genuine interest in keeping themselves well. The word "dramatize" connotes plays and costumes and properties, but these elaborations are not necessary.

Children, as a rule, are delighted to learn that their milk and their daily orange juice help to make strong bones and good teeth. They take a keen interest in the "pump" that sends the blood through their body and the "heating system" that keeps them warm even when they play out in the snow. The idea of getting every possible germ off the hands and face before eating is quite exciting and makes a thorough wash-up before meals an important piece of business much more interesting than cleanliness alone.

Once a child realizes that different foods serve different purposes in making him grow and keep well, he's quite likely to eat happily while he discusses the muscles he expects to develop for tree climbing, bike riding, and so on.

Such "dramatization" can be done at home where parents are well informed and interested in the method. Some of it certainly must be done in the schools. But in neither place does it need to be a formal, burdensome process.—Porterville *Recorder*.

COMMITTEE ON PUBLIC RELATIONS†

Animal Experimentation: Radio Broadcast by Lewis A. Alesen:

Strong arguments against vivisection were advanced by Dr. Lewis A. Alesen, secretary of the Los Angeles County Medical Association, in a radio broadcast given in San Francisco the evening of July 21. The arguments were up-to-date facts known to the medical profession; their use was to combat the time-worn claims of antivivisectionists, who apparently are unable to unearth new or unemotional reasons for stopping scientific work conducted with animals. While medicine progresses with the aid of animals, antivivisection claims remain in the same niche they carved out for themselves years ago.

Doctor Alesen's broadcast was part of a public service program sponsored by radio station KQW, with a studio

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. Donald Cass of Los Angeles is the chairman, and Mr. John Hunton is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Mr. John Hunton, Room 2004, Four Fifty Sutter Street, San Francisco.

in San Francisco and transmitting station in San Jose. The broadcast was a forum program, in which Alexander Mooslin, San Francisco attorney, took the antivivisection side and Ernest E. Weihe, San Francisco architect, represented the public. Lewis E. Haas, San Francisco public relations counsel, acted as moderator.

The thanks of the Committee on Public Relations are due to Doctor Alesen for his splendid presentation of this subject, and the committee takes this oportunity to express its thanks publicly. H.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Inyo-Mono County Medical Society

Postgraduate Meeting: Conference on Organized Medicine

Inyo-Mono County Medical Society held a meeting last Friday, June 27, in the Methodist church in Bishop. Guest speakers of the evening were Dr. George Kress, secretary of California Medical Association; Dr. Louis Packard, councilor for California Medical Association for districts of Bakersfield, Kern, Tulare, Inyo and Mono counties; Dr. J. C. Savage of Los Angeles, who is connected with St. Vincent's hospital; Dr. Roderick A. Ogden of Bakersfield; Dr. Lloyd H. Fox of Bakersfield.

At this meeting the dentists of Inyo county were taken into the medical society as affiliate members. Dentists present were Dr. J. C. Baxter, Dr. Ed Bulpitt and Dr. Choate of Bishop.

Twenty-three were present altogether, including several wives. Mrs. Packard, who is councilor for the women's society, made a plea to the group that the wives of the Inyo-Mono county doctors form an auxiliary unit to aid the doctors in their undertakings. Officers have been elected in the newly formed Woman's Auxiliary and are Mrs. Harvey W. Crook, president; Mrs. L. S. Bambauer, vice-president, and Mrs. Clarence L. Scott, secretary-treasurer, all of Bishop.—Independence *Independent*, July 4.

* * *

Postgraduate Medical Courses for Practicing Physicians*

Stanford University School of Medicine, in coöperation with the San Francisco Department of Public Health and the San Francisco Hospital, on September 8-12, 1941, inclusive, will present a series of postgraduate courses for physicians. Each physician may take one morning and one afternoon course, or a full-day course, and all physicians should attend the evening general meetings. There will be a registration fee of twenty-five dollars. An additional fee of ten dollars will be made to cover the cost of materials used in Course 6, Surgical Anatomy and Operative Technic, and in Course 8, Ophthalmology. Registration closes August 30, 1941. All fees are payable to Stanford University School of Medicine. Checks and applications for registration in these courses should be mailed to the Dean, Stanford University School of Medicine, 2398 Sacramento Street, San Francisco, not later than August 30.

* * *

OUTLINE OF COURSES

MORNING COURSES

Monday, Tuesday, Wednesday, Thursday and Friday 8:30-12

Course 1—Gynecology

About half of this course will be devoted to diagnostic procedures, therapeutic agents and fundamentals of treatment of endocrine disturbances affecting the sex organs of women. The remainder of the course will take up obstetrical analgesia and anesthesia, the use of vitamins in obstetrics, certain aspects of infertility and abortion.

Course by Drs. D. A. Dallas, L. A. Emge, C. F. Fluhmann, T. Henshaw Kelly, Lewis Michelson, A. V. Pettit, K. L. Schaupp, and H. A. Stephenson.

Course 2—Medical Diagnosis and Treatment

This course will consider only a few diseases (the anemias and bleeding diseases, hepatitis, peptic ulcer, renal disease and hypertension, diabetes mellitus, etc.). Special attention will be given to the interpretations of laboratory data as diagnostic and therapeutic aids, and to the use of the sulfonamides in infectious diseases.

Course by Drs. C. W. Barnett, A. L. Bloomfield, Garnett Cheney, Windsor Cutting, L. A. Rantz, and David Rytand.

Course 3—Diseases of the Genito-Urinary Tract

This course will review the common disorders of the genito-urinary tract by lectures and discussions, and by demonstrations of diagnostic and treatment methods in the out-patient clinic, ward rounds, operative and cystoscopic clinics.

Course by Drs. J. R. Dillon, James Ownby, L. R. Reynolds, and William Sumner.

* * *

AFTERNOON COURSES

Monday, Tuesday, Wednesday, Thursday and Friday 1:30-5

Course 4—Diagnosis and Treatment of Malignant Tumors

This course will consider (1) present-day theories of the origin and nature of cancer, (2) methods for diagnosis, including the criteria of malignancy, indications and technic for biopsy, and (3) principles of surgical and radiological treatment, with discussion of the specific indications offered by the various histological and regional groups of tumors.

Course by Drs. W. E. Borley, J. R. Dillon, L. G. Dobson, L. A. Emge, L. H. Garland, E. F. Holman, G. V. Kulchar, Edward Leef, R. C. McNaught, R. R. Newell, F. L. Reichert, Robert Scarborough, and D. A. Wood.

Course 5—Cardiovascular Diseases

This course will consist of clinics and discussions on various aspects of cardiovascular disease with particular reference to diagnosis and treatment. There will also be discussions of various laboratory procedures including electrocardiography and fluoroscopy with special emphasis on their use in practice. A portion of the time will be devoted to peripheral vascular disease.

Course by Drs. C. W. Barnett, A. L. Bloomfield, J. K. Lewis, Lester Lipsitch, Carol McKenney, R. R. Newell, W. W. Newman, W. H. Northway, Ann Purdy, L. A. Rantz, J. M. Read, F. L. Reichert, and D. A. Rytand.

Course 6—Surgical Anatomy and Operative Technic (limited to twenty-four physicians)

This course will be conducted in the dissecting room and the experimental laboratories; will include dissection of special regions and instruction and practice in the technic of various operations.

An additional fee of ten dollars will be charged to cover the cost of material used in this course.

Course by Drs. Donald King, G. W. Nagel, and Hall Seely.

* * *

FULL-DAY COURSES

Monday, Tuesday, Wednesday, Thursday and Friday Mornings, 9-12; Afternoons, 2-5

Course 7—Surgical Emergencies, Traumatic Injuries and Fractures (At San Francisco Hospital)

This course will include lectures, demonstrations, and ward rounds, dealing with the diagnosis and treatment of conditions related to trauma.

Course by Drs. Edmund Butler, J. W. Cline, Charles E. Cooper, Leo Eloesser, Frederick Fender, W. Wallace Greene, Bert L. Halter, Delbert Hand, Nelson Howard, Russell Klein, Frank Lusignan, Carleton Mathewson, Jr., J. Minton Meherin, and E. J. Morrissey.

Course 8—Ophthalmology (Limited to fifteen. This course for specialists only)

This course will include practical demonstrations of eye operations in the laboratory, with performance of these operations by the class and didactic lectures on select subjects. There will be four afternoon demonstrations of selected out-patient material and one afternoon of operative clinic.

An additional fee of ten dollars will be charged to cover the cost of anatomical materials used in this course.

Course by Drs. Hans Barkan, J. W. Bettman, W. E. Borley, S. F. Boyle, Samuel Engel, Max Fine, Avery Hicks, R. S. Irvine, and Dohrmann Pischel.

†Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

* See letter on page 110.

Course 9—Anesthesiology (Limited to eight physicians. Only those whose practice already includes anesthesiology will be eligible for this course)

This course will review preliminary medication; the newer anesthetic agents; the rectal, intravenous, and inhalation methods of administrations; obstetric analgesia and anesthesia; posture during anesthesia.

Course by Drs. Emelie Andersen, Winifred Golenternek, Grace Gunn, William B. Neff, Lorruli Rethwilm, John A. Stiles and Laverne Wright.

GENERAL MEETINGS

Tuesday, Wednesday and Thursday Evenings

Lane Hall—8-10 o'clock

Meeting 1. Tuesday Evening, September 9—*The Use of Physical Therapy in Modern Medicine,* Dr. W. H. Northway.

Meeting 2. Wednesday Evening, September 10—*Behavior Problems in Pediatric Practice,* Dr. Hale F. Shirley and Dr. Mary H. Layman.

Meeting 3. Thursday Evening, September 11—*Everyday Problems in Industrial Medicine,* Dr. Rodney Beard, Dr. Nelson J. Howard and Dr. William Shepard.

COMMITTEE ON MEDICAL ECONOMICS

Locum Tenens Agreements Should Be Specific

We quote from the minutes of the February 4, 1941, meeting of the Board of Trustees of The Medical Society of the State of Pennsylvania introductory to a discussion of the subject and publication of two forms of agreement:

President Borzell read correspondence between himself and our society's legal counselor regarding the possibility of dual payment of income tax; first, by physicians serving as locum tenens in the absence of physicians in military service; and, later, by the absent physician on his share of fees collected by the locum tenens. Doctor Mayock moved, seconded by Doctor Samuel, and unanimously carried, that at the conclusion of the discussion of this subject between Doctors Dorzell, Donaldson, and the legal counselor, if found advisable, the outcome be widely dispersed. (The Executive Committee of the Board of Trustees at its meeting on March 12 advised publication.)

The Federal Internal Revenue Department has ruled that where a physician simply takes over the practice of another under an agreement to pay a certain percentage of the cash collected to the absent physician, an income tax must be paid both on the total net collections of the locum tenens and again paid by the absent physician on the percentage of receipts turned over to him. The theory is that unless an existing agreement clearly indicates the contrary, the locum tenens is in effect purchasing a capital asset; namely, a practice, and that the sums which he pays to the absent practitioner are not deductible expenses.

Our society's legal counselor in submitting agreements Nos. 1 and 2 is attempting to make it clear that the arrangement is only for a specified period of time, and that the practice of the absent physician has not been purchased.

With no attempt to create the impression that such an arrangement will be acceptable to the Department of Internal Revenue, the attorney proffers the two agreements. In No. 1, whatever risk from a tax standpoint is involved, it shall be borne by the absent practitioner; in No. 2, by the locum tenens.

It is of course obvious in both suggested agreements that where the locum tenens is an established neighboring physician the clause covering the location for practice after the return of the absent practitioner is superfluous, but it would be applicable in all instances where an outside physician has been imported as locum tenens.

Two agreements are printed below. Although our legal counselor is unwilling to venture a definite opinion that either of them will be acceptable to the Department of Revenue, it is his opinion that they represent the best possible attempt to avoid the double taxation feature.

AGREEMENT NO. 1

....., 1941.

Dear Doctor B:

I hereby employ you to take care of my patients from ....., 1941, to December 31, 1941, both inclusive, and agree to pay you a salary of 40 per cent of the fees paid by my patients for medical attention rendered by you, and also agree to reimburse you for the actual expenses incurred by you in the care of my patients, but not in excess of 10 per cent of the fees paid by my patients for medical attention rendered by you.

It is understood that this agreement may be terminated by either of us at any time upon.....days' written notice thereof given to the other, but, unless sooner terminated, shall continue for the above-mentioned period.

Upon the termination of this agreement it is understood that you will not engage in the practice of medicine or surgery within a radius of.....from....., for a period of.....

If the above is acceptable to you, kindly indicate your acceptance thereof as indicated below.

Yours very truly,

Dr. A.

This.....day of..... 1941, I accept the above employment upon the above-mentioned terms and conditions.

.....

Dr. B.

AGREEMENT NO. 2

....., 1941.

Dear Doctor B:

I hereby authorize you to take care of my patients from ....., 1941, to December 31, 1941, with the understanding that you pay me 50 per cent of the fees paid by my patients for medical attention rendered by you, and with the further understanding that this authority shall terminate with the termination of this agreement, which may be terminated by either of us at any time upon .....days' written notice thereof given to the other, but this agreement unless sooner terminated shall continue for the above-mentioned period.

Upon the termination of this agreement it is understood that you will not engage in the practice of medicine or surgery within a radius of.....from..... for a period of.....

If the above is acceptable to you, kindly indicate your acceptance thereof as indicated below.

Yours very truly,

Dr. A.

This.....day of..... 1941, I accept the above and agree to take care of the above-described patients upon the above-mentioned terms and conditions.

.....

Dr. B.

—*Pennsylvania Medical Journal,* April, 1941.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (14)

Kern County (2)

John J. Cawley, *Bakersfield.*
Francis J. Gundry, Jr., *Bakersfield*

Mendocino-Lake County (1)

Ruth L. Green, *Talmage*

Monterey County (1)

J. W. Buehler, *Aromas*

Orange County (2)

Lawrence L. Bean, *Santa Ana*
Lloyd F. Smith, *Fullerton*

San Diego County (4)

E. L. Bormann, *San Diego*
Rollin M. Falk, *San Diego*
Norman N. O'Farrell, *San Diego*
Samuel N. Palevsky, *San Diego*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

San Francisco County (3)

Josef H. Nussenfeld, *San Francisco*
John A. Spencer, *San Francisco*
Emanuel Windholz, *San Francisco*

Tulare County (1)

Fred E. Cooley, *Dinuba*

In Memoriam

Cain, William Thomas. Died at Gardena, June 18, 1941, age 60. Graduate of Kentucky School of Medicine, Louisville, 1904. Licensed in California in 1922. Doctor Cain was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Conn, Carl Edwin. Died at Hollywood, July 6, 1941, age 66. Graduate of State University of Iowa College of Medicine, Iowa City, 1895. Licensed in California in 1920. Doctor Conn was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Smith, Clyde Livingston. Died at Los Angeles, May 17, 1941, age 62. Graduate of University of Illinois College of Medicine, Chicago, 1902. Licensed in California in 1919. Doctor Smith was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Smith, John Lawrence. Died at Los Angeles, June 26, 1941, age 74. Graduate of Rush Medical College, University of Chicago, 1901. Licensed in California in 1901. Doctor Smith was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

OBITUARY

Edward William Hanlon, M. D.
1872-1941

Edward William Hanlon is dead.

He died as quietly and unobtrusively and gently as he lived. In death, as in life, he had the love, respect, and admiration of all who knew him. Doctor Hanlon was born January 24, 1872, in San Diego, the son of John and Catherine Hanlon. He attended St. Vincent's College in Los Angeles, and from there went to Columbia University Medical School, from which he received his degree of M. D. in 1893. He took one year's internship at St. Elizabeth's Hospital in Patterson, returning to California in July, 1894, when he was licensed to practice medicine.

In the latter part of 1894, Doctor Hanlon settled in Marysville, California, where he engaged in general practice until January, 1906. About that time he had decided to devote his time and skill to the subject which interested him for many years; namely, gastro-enterology. In order to prepare himself for this specialty he returned to New York for further study, but soon learned that the courses he desired were not available there. In the meantime, his fiancée, Miss Mary Kelly, of Napa, California, came to New York and they were quietly married on the 19th of March, 1906. Doctor Hanlon and his bride then proceeded to Europe, where he studied in Berlin, Vienna and Goettingen.

In December, 1907, after a year and eight months in Europe, they returned to the United States where he opened an office in Los Angeles, specializing as he intended to, in the diseases of the digestive tract. In 1908 their one child was born. Doctor Hanlon remained in Los Angeles until the fall of 1913, when he came to San Francisco. Here he gained his great reputation as an outstanding consultant and practitioner in his specialty.

A. B. D.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. HARRY O. HUND.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM.....Asst. Chairman on Publicity

Official Notices

State Board Meeting.—The President, Mrs. Harry O. Hund, has called a meeting of the State Board of the Woman's Auxiliary to be held on Friday, September 19, in San Francisco. All presidents of county auxiliaries are invited to attend this meeting.

* * *

State Board members for 1941-1942 are: President, Mrs. Harry O. Hund of San Rafael; president-elect, Mrs. F. G. Lindemulder, San Diego; first vice-president, Mrs. R. Stanley Kneeshaw, San Jose; second vice-president, Mrs. Ralph B. Eusden, Long Beach; recording secretary, Mrs. R. K. Cutter, Berkeley; corresponding secretary, Mrs. Frank A. Lowe, San Francisco; treasurer, Mrs. Edmund Morrissey, San Francisco; councilors-at-large: Mrs. Eric Colby, Bakersfield; Mrs. R. Emerson Bond, San Diego; Mrs. Rene Van de Carr, Piedmont, and Mrs. Franklyn D. Hankins, Riverside.

District Councilors: Mrs. G. W. Coon of Riverside for First District, Mrs. Franklin Farman of Los Angeles for Second District, Mrs. Louis Packard of Bakersfield for Third District, Mrs. J. C. McClure of Lindsay for Fourth District, Mrs. Allen Pederson of Santa Cruz for Fifth District, Mrs. M. R. Gordon of San Francisco for Sixth District, Mrs. Kaho Daily of Richmond for Seventh District, Mrs. C. C. Landis of Chico for Eighth District, and Mrs. H. Randall Madeley of Vallejo for Ninth District.

The chairmen of standing committees appointed from this group are: Membership and Organization, Mrs. R. Stanley Kneeshaw; Program and Health Education, Mrs. Ralph B. Eusden; Finance, Mrs. F. G. Lindemulder; Public Relations, Mrs. Eric Colby; Public Health Activities, Mrs. R. Emerson Bond; Editor and Publicity, Mrs. Rene Van de Carr; *Hygeia*, Mrs. Franklyn D. Hankins; Convention, Mrs. John C. Sharp; Historian, Mrs. Arthur Newcomb; and Parliamentarian, Mrs. Hobart Rogers. Mrs. Franklin Farman is chairman of a Special Committee on Medical Benevolence Fund.

* * *

News

Mrs. A. E. Anderson, past State President of the Woman's Auxiliary, was elected second vice-president of the

† As county auxiliaries to the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Rossner Graham, Assistant Chairman on Publicity, 6101 Acacia Avenue, Oakland. Address of the Chairman on Publicity: Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont.

For roster of officers of state and county auxiliaries, see advertising page 6.

Woman's Auxiliary to the American Medical Association at the national convention held in Cleveland from June 2 to June 6. Mrs. Anderson will be Organization Chairman of the Western Division.

Twelfth Annual Convention, Woman's Auxiliary to the California Medical Association, May 6, 1941

FIRST MEETING

The first meeting of the Twelfth Annual Convention of the Woman's Auxiliary to the California Medical Association was called to order at 10 a. m., Tuesday, May 6, 1941, at the Peninsula Country Club, Monterey, by the President, Mrs. A. E. Anderson.

The Invocation was offered by Reverend Theodore Bell; the Convention Chairman, Mrs. John C. Sharp, was introduced by Mrs. A. E. Anderson; the address of welcome was given by Mrs. Martin McAulay, Monterey County, and the response was read by Mrs. H. Randall Madeley of Solano County.

IN MEMORIAM

Mrs. Kaho Daily of Contra Costa County conducted a beautiful candle ceremony, giving tribute to the memory of those members who have passed away during the year. The ceremony was concluded with music by Mrs. Milton Shutes, accompanied by Dr. Charles Greenwood.

Alameda County, Mrs. William Strietman; Contra Costa County, Mrs. Charles Blake; Los Angeles County, Mrs. H. E. Scheffbauer, Mrs. Charles L. Bennett, Mrs. J. M. Nielson, Mrs. Frances McLaren; Orange County, Mrs. H. A. Johnston; San Diego County, Mrs. J. H. Young, Mrs. C. Randall.

ROLL CALL

By the Secretary, Mrs. R. K. Cutter.

REPORTS OF CONVENTION COMMITTEES

Credentials.—Mrs. Otto Diederich reported the following registrations:

Officers and State Board members	18
Delegates	69
Alternates	17
Members and guests	132
Total	236

REPORTS OF OFFICERS

President's Message.—Mrs. Harry O. Hund took the chair while the President, Mrs. A. E. Anderson gave her report, a résumé of the work accomplished during the year. Mrs. George Calvin of Alameda County moved that the report be accepted with deepest appreciation. Motion seconded and carried. A spontaneous rising vote of thanks was given the President.

Corresponding Secretary.—The report of Mrs. E. R. Scarboro was read. It was accepted by the President and placed on file.

Treasurer.—Mrs. C. G. Stadfield read her report which showed the following balances:

Checking Account	$1,101.91
Savings Account	1,619.97
Total	$2,721.88

This report was ordered placed on file.

Auditor.—The report of the Auditor was read by the Secretary. Mrs. McGovney of Santa Barbara moved and it was seconded that this report be accepted. Motion carried.

Finance.—Mrs. Harry O. Hund read the budget proposed for the coming year, 1941-1942:

Stationery and Printing	$ 100.00
Stenographic and Clerical Help	125.00
Postage	75.00
Telephone and Telegraph	60.00
Convention	150.00
Courier	375.00
President's Discretionary Fund	300.00
Membership and Organization	100.00
Miscellaneous	30.00
Total	$1,315.00

Mrs. Hund moved the adoption of this budget. Motion seconded and carried.

Dues.—Mrs. Harry O. Hund moved that the annual dues for 1941-1942 remain at $1. Motion seconded and carried.

REPORTS OF STANDING COMMITTEES

Mrs. Forman, Los Angeles, moved and it was seconded that these reports be accepted as a whole. Motion seconded and carried.

Membership and Organization: Mrs. F. G. Lindemulder reported.

Program and Health Education: Mrs. Harry Huffman reported.

Public Relations: Mrs. A. A. Alexander reported.

Public Health Activities: Mrs. Eugene S. Kilgore reported.

Editor and Publicity: Mrs. William Boeck reported.

Hygeia: Mrs. Louis Packard reported.

Mrs. Kilgore moved that we accept the reports of the Standing Committees. Motion seconded and carried.

REPORTS OF SPECIAL COMMITTEES

Legislative.—Mrs. Charles Kennedy's report was read and placed on file.

Historian.—Mrs. A. T. Newcomb's report was read and placed on file.

Recommendations from the State Board.—These were read by the Secretary.

The State Board recommends that since we are facing a great national crisis, the California Auxiliary feels it would be unwise to increase national dues. After discussion, Mrs. Percy of Los Angeles moved, and Mrs. Rogers, Alameda, seconded that this convention go on record as being opposed to any raise in national dues at this time and that the National Secretary be notified to that effect, so that this can be presented to the National Board at the convention at Cleveland, Ohio, in June. Motion carried.

Mrs. J. F. Percy moved that the convention recommend to the incoming Board that a Revision Committee be appointed to study such changes as should be made by next convention. Motion was seconded and carried.

Report of Nominating Committee.—Mrs. Franklin Farman, chairman, read the following report:

President-Elect.....Mrs. F. G. Lindemulder, San Diego Co.
1st Vice-President.....Mrs. R. S. Kneeshaw, Santa Clara Co.
2d Vice-President.....Mrs. Ralph Eusden, Los Angeles Co.
Recording Secretary.....Mrs. R. K. Cutter
Treasurer.....Mrs. E. J. Morrissey, San Francisco Co.
Councilors-at-Large
Mrs. R. Emerson Bond.....San Diego County
Mrs. Eric F. Colby.....Kern County
Mrs. F. D. Hankins.....Riverside County
Mrs. Rene Van de Carr.....Alameda County

Signed
Mrs. Franklin Farman, *Chairman.*
Mrs. George Calvin.
Miss Julia Koenecke.
Mrs. Willard F. Newman.
Mrs. G. Wendell Olson.

The meeting adjourned to be followed by a luncheon at Pebble Beach Lodge, honoring Mrs. A. E. Anderson, President.

Respectfully submitted,

Mrs. R. K. Cutter, *Recording Secretary.*

* * *

SECOND MEETING

The second meeting of the Twelfth Annual Convention of the Woman's Auxiliary to the California Medical Association was called to order at 10:05 a. m., May 7, 1941, at

the Peninsula Country Club, Monterey, California, with the President, Mrs. A. E. Anderson, presiding.

Credentials.—Mrs. Otto Diederich reported the following registration as of 10 a. m., Wednesday, May 7, 1941: Officers and State Board members, 19; delegates, 75; alternates, 17; members and guests, 143; total, 254.

Minutes.—The Secretary, Mrs. R. K. Cutter, read the minutes of Tuesday, May 6, which were accepted as read.

Report of District Councilors.—Mrs. E. K. Canelo of San Jose moved, and it was seconded and carried, that the reports of the district councilors be accepted as a whole. Mrs. Stanley Truman moved that the reports be accepted as read and placed on file. Motion was seconded and carried.

Report of County Presidents.—Mrs. Eugene Kilgore of San Francisco moved, and it was seconded, that these reports be accepted as a whole. Motion carried.

Mrs. Huffman moved, and it was seconded, that the reports of absent county presidents be placed on file if no member has been delegated to read her report. Motion carried.

Mrs. P. J. Hanzlik moved, and it was seconded, that we accept and place on file the reports as read. Motion carried.

Report of Committee on Resolutions.—Mrs. Hobart Rogers, Alameda, presented the following report:

WHEREAS, The Twelfth Annual Session of the Woman's Auxiliary is now drawing to a close, and

WHEREAS, Many have added to the success and pleasure of this Convention; therefore, be it

Resolved, That the Woman's Auxiliary to the California Medical Association in Convention assembled extend its sincere thanks and grateful appreciation:

1. To Mrs. Axcel E. Anderson, our President, whose charming personality and executive ability has endeared her to every member of the Auxiliary, and to the members of the Board of Directors who have so ably carried out their duties to a successful completion.

2. To Mrs. John C. Sharp and her Committees who have worked untiringly for the success of the sessions and the pleasure of the members and guests.

3. To the Reverend Theodore Bell who asked God's blessings on this Convention.

4. To Mrs. Milton Shutes and Dr. Charles Greenwood for the music for Memorial services.

5. To the Carmel Players for the very delightful evening honoring Mrs. Harry Wilson, wife of the President of the California Medical Association.

6. To the Management and Staff of the Hotel Del Monte and the Peninsula Country Club for their courtesies.

7. To the Council of the California Medical Association for their support during the year.

8. To Dr. Harry Wilson and the members of our Advisory Council for their coöperation and support and for their sympathetic understanding of our problems as an Auxiliary.

9. To Dr. Philip K. Gilman and to Dr. Chauncey Leake for their inspiring and enlightening messages.

10. To Lieutenant-Colonel Krafft for his kindness in planning for us an interesting and educational tour of the Hospital at Fort Ord; and be it further

Resolved, That copies of these Resolutions be sent by the Recording Secretary of the Convention to the above named, to whom we are deeply indebted, and a copy be placed on file.

Signed:
MRS. HOBART ROGERS
MRS. A. LINCOLN BROWN
MRS. GUY MANSON

Mrs. Hobart Rogers moved and Mrs. A. A. Alexander seconded the adoption of these resolutions. Motion carried.

Election of Officers.—Report of the Nominating Committee was read again by Miss Julia Koenecke.

There being no nominations from the floor, Mrs. Stanley Truman, Alameda, moved, Mrs. Kaho Daily, Contra Costa, seconded that the nominations be closed, and the Secretary be instructed to cast a unanimous ballot for the officers named in the report. The President declared them duly elected.

District Councilors.—The President called for nominations for District Councilors.

Third District: Mrs. C. W. Henderson nominated Mrs. Louis A. Packard, Bakersfield.

Fifth District: Mrs. Charles Moore nominated Mrs. Allan Pederson, Santa Cruz.

Sixth District: Mrs. Gerald O'Connor nominated Mrs. M. R. Gordon, San Francisco.

Seventh District: Mrs. Floyd Bell nominated Mrs. Kaho Daily, Contra Costa County.

Eighth District: Mrs. M. L. Azevedo nominated Mrs. C. C. Landis, Chico.

Ninth District: Mrs. Jones nominated Mrs. H. R. Madeley, Solano.

Mrs. D. C. Oakleaf, Sonoma, moved and it was seconded that the nominations be closed. Motion carried, and District Councilors were elected by viva voce vote.

Election of Three Members of Nominating Committee for 1942.—Mrs. Ralph Eusden nominated Mrs. Clifford Wright, Los Angeles; Mrs. Abbott Crum nominated Mrs. A. A. Alexander, Alameda County; Mrs. B. Lamkin nominated Mrs. Otto Diederich, Fresno.

Mrs. Stadfield moved that the nominations be closed. Motion was seconded and carried.

Announcements.—Mrs. Richard McGovney announced a request from Mrs. Ullmann that Auxiliaries help in the Cancer Control fight through entertainments and $1 memberships.

Introduction of New Officers.—Mrs. A. E. Anderson presented Mrs. Harry O. Hund, President for 1941-1942, who responded, and introduced the newly elected officers.

Credentials.—Mrs. Otto Diederich read the final report on credentials and registrations: Officers and State Board members, 18; delegates, 78; alternates, 20; members and guests, 142; total, 258.

Minutes.—The Secretary read the minutes of this meeting, which were accepted as read.

There being no further business, the Twelfth Annual Convention adjourned.

Respectfully submitted,
MRS. R. K. CUTTER, *Recording Secretary.*

CALIFORNIA PHYSICIANS' SERVICE†

BENEFICIARY MEMBERSHIP

September, 1939	1,220
March, 1940	9,322
September, 1940	17,398
March, 1941	24,107
June, 1941	27,632

* * *

California Physicians' Service is anxious to take the maximum advantage of the opportunity to work with local county medical societies through the coördinating committees now being named in each society. In order to give such committees all available information on California Physicians' Service, a series of monthly reports is being

†Address: California Physicians' Service, 333 Pine Street, San Francisco. Telephone EXbrook 3211. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

prepared. The initial report will be released in August. This initial report will review the history and organization of California Physicians' Service and will give statistics based on the first year's experience. Subsequent reports will be progressive in two sections: (1) narrative material describing current operation policies, and (2) statistical material developed from actual records in the California Physicians' Service office.

The initial report will also contain the revised fee schedule approved by the Board of Trustees of California Physicians' Service at Del Monte. This fee schedule is based on several months of conference and study by the California Physicians' Service Fee Schedule Committee and appointed representatives of various scientific sections of California Medical Association. It is subject to revision at the discretion of the Board of Trustees.

It is hoped that these reports will provide participating physicians with current information descriptive of the month-by-month operation of the California Physicians' Service with summaries provided periodically for purposes of comparison. A copy of the report will be placed in the hands of the Secretary of each County Medical Society, where it will be readily accessible to all members of the society as well as to the members of the Coördinating Committee.

* * *

A. E. Larsen, M. D., who has been carrying the dual responsibility of Secretary and Medical Director of California Physicians' Service and Medical Director of the Farm Security Administration, has assumed full time status with California Physicians' Service during July. In the judgment of the Board of Trustees of California Physicians' Service, the volume of work falling upon the person acting as Secretary and Medical Director of California Physicians' Service, with the beneficiary membership now approximately 30,000 and constantly increasing, is too time-consuming to be handled on a part-time basis.

Dr. Larsen has recently been appointed Clinical Instructor in Medicine by the Regents of the University of California.

* * *

Medical Aid Is Assured City Crews

Group Insurance Provides for 2,000 Listed on Pay Rolls

Complete medical, surgical and hospital care at a nominal rate were made available to 2,000 city employees yesterday when a contract between *California Physicians' Service,* a nonprofit organization sponsored by the California Medical Association, and the City Employees Association of Long Beach was signed in the office of Attorney Harry Albert, legal representative of the city employees, according to Dewey Vaughn, president of the association.

This plan is being watched by physicians all over the nation with marked interest. It provides three weeks of hospitalization for any one illness, for any number of separate illnesses a year, and medical and surgical attention for conditions which arise after the time the contract is signed.

Hospitalization may be obtained for the wife and all dependents of the insured under 19 years of age for a small additional monthly payment.

Dr. H. Milton Van Dyke,, president of the Harbor Branch of the Los Angeles County Medical Association, stated that California Physicians' Service is looking forward to the day when medical and surgical coverage for dependents as well as hospitalization will be available.

The hospital insurance is good anywhere in the United States in any lawfully operated hospital. Medical and surgical attention can be obtained anywhere in California.—Long Beach *Press.*

* * *

Interesting Article on Health Insurance

But Health Insurance Is Different, by Nathan Sanai, is the title of an article in the August number of *Harper's Magazine.* This article is well worth the time for every California physician to read. It describes with great clarity the problems confronting prepaid medical service plans. It contains many weighted statements of significance:

> The battle for health insurance is over. . . . The job of making health insurance work has just began. . . . Health insurance must turn into a little known path that offers only a few markers. . . . In certain fields of medical care no satisfactory information exists for the actuary. The most important gaps relate to diagnostic services, including those of specialists as consultants—laboratory facilities, etc. . . . There is an important place for experimental plans, for laboratories where different methods of practice and of payment may be tried and analyzed. . . . Under these conditions one may easily correct an error that might prove *disastrous* if it were made into a system with millions of subscribers and thousands of physicians. . . . Health insurance is in motion and behind it there is dynamic power that has as its source in the increasing public demand for relief from the economic hazard of sickness.

This article should be of special interest to physicians because its own "California Physicians' Service" is the only "laboratory" of its kind which is attempting to adjust the health [sickness] insurance principle to the traditional practice of medicine.

MEDICAL EPONYM

Gruber-Widal Test

The Gruber-Widal test is based on the theoretical investigations of Max von Gruber (1853-1927) of the Department of Hygiene in the University of Munich, and their practical application by Fernand Widal (1862-1929). Von Gruber, in an article entitled "Theorie der activen und passiven Immunität gegen Cholera, Typhus und verwandte Krankheitsprozesse [Theory of Active and Passive Immunity to Cholera, Typhoid Fever and Related Diseases]," which appeared in the *Münchener medizinische Wochenschrift* (43:206, 1896), concludes:

> By means of intraperitoneal inoculation, with the killed culture of the vibrio of cholera, . . . the typhoid bacillus, and the colon bacillus, a high-grade and persistent immunity may be achieved in the guinea pig. . . . Antibodies are present in the blood and body fluids of the immunized animals. . . . The essential effect of the antibodies of the body fluids in these immunized animals consists in a destructive alteration of the enveloping structures of the bodies of the bacteria. This is shown by the fact that bacteria treated with these fluids become viscid, collect in large clumps and lose their individual motility.

Widal, in his article "Sero-diagnostic de la fièvre typhoïde [The Serum Diagnosis of Typhoid Fever]," which appeared in the *Bulletins et mémoires de la Société medicale des hôpitaux de Paris* (13:561-566, 1896), after acknowledging his debt to Pfeiffer, Koll and von Gruber, says:

> We present a new method, which makes possible the diagnosis of typhoid fever simply by observing the effect of the patient's serum on a bouillon culture of Eberth's bacillus. . . . A small amount of blood . . . is collected under aseptic precautions; . . . the serum is decanted, and several drops are added to a tube of broth in the proportion of one part of serum to ten or fifteen parts of bouillon. . . . After twenty-four hours, the bouillon is only faintly clouded; a few floccules have settled to the bottom, and a whitish, rather heavy suspension is visible throughout the length of the tube. . . . Inspection of the tube is not enough; miscroscopic examination is also necessary. . . . The bacilli, instead of wriggling all over the preparation . . . are seen to be grouped, agglutinated together. . . . The diagnosis may also be made more quickly. . . . It may be so apparent that six drops of serum mixed with 4 cc. of culture, after being kept at room temperature for two or three hours, will produce the characteristic clumping to the naked eye. . . . The diagnosis must never be made until after microscopic examination. . . . If one drop of serum is added to ten drops of a culture of Eberth's bacillus, one may almost immediately demonstrate the characteristic bacterial agglomeration under the microscope.—R. W. B. in *New England Journal of Medicine,* March 13, 1941.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.†

California Medical Association, Hotel Del Monte, Del Monte, California, May 4-7, 1942.

American Medical Association, Atlantic City, June 8-12, 1942.

Medical Broadcasts.*

Los Angeles County Medical Association.

The following is the Los Angeles County Medical Association's broadcast schedule for the month of August, 1941:

Saturday, August 2—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, August 2—KFI, 9:45 a. m., The Road of Health.
Saturday, August 9—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, August 9—KFI, 9:45 a. m., The Road of Health.
Saturday, August 16—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, August 16—KFI, 9:45 a. m., The Road of Health.
Saturday, August 23—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, August 23—KFI, 9:45 a. m., The Road of Health.
Saturday, August 30—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, August 30—KFI, 9:45 a. m., The Road of Health.

Basic Science Law: References.‡—A list of reports on basic science laws, printed in CALIFORNIA AND WESTERN MEDICINE, includes:

Vol. 27, No. 4, October, 1927, page 535. Editorial: "A New Method of Medical Licensure—The Basic Science Laws of Wisconsin, Connecticut, Washington, and Minnesota."

Vol. 31, No. 4, October, 1929, page 285. Editorial: "Basic Science Law—Would It Better Conditions in California?"

Vol. 32, No. 4, April, 1930, page 288. One hundred and eighty-sixth meeting of the Council of the California Medical Association. Item 30, Medical Practice Act and Basic Science Act.

Vol. 32, No. 6, June, 1930, page 430. Report of Special Committee on Revision of Medical Practice Act and of a possible Basic Science Act.

Vol. 34, No. 6, June, 1931, page 448. Report of Special Committee on California Medical Practice Act and on a Proposed Qualifying Certificate (so-called Basic Science) Law.

Vol. 35, No. 3, September, 1931, page 228. Editorial: "California Medical Practice Act—Its new Amendment Relating to Board Appointments."

Vol. 35, No. 3, September, 1931, page 239: "California Medical Practice Act."

Vol. 35, No. 2, February, 1932, page 128. Report of Special Committee on Medical Practice Act and on Qualifying Certificate Law.

Vol. 35, No. 6, June, 1932, page 439. Report of Special Committee on California Medical Practice Act and on a Qualifying Certificate (so-called Basic Science) Law.

Vol. 41, No. 5, November, 1934, page 339. Editorial: "Should California Have a Qualifying Certificate for the Learned Professions?"

Vol. 42, No. 1, January, 1935, pages 39 and 53. Editorial: "University Presidents Endorse Proposed Qualifying Certificate Act," report of Special Committee on Medical Practice Act and on Qualifying Certificate Law.

Vol. 43, No. 4, October, 1935, page 304. Report of Committee on Basic Science Act.

Vol. 43, No. 5, November, 1935, page 321. Editorial: "On a Qualifying Certificate (Basic Science) Initiative Law for California."

Vol. 43, No. 6, December, 1935, page 395. Editorial: "Referendum on Proposed Qualifying Certificate (Basic Science) Initiative Law for California."

Vol. 44, No. 1, January, 1936, page 2. Editorial: "Qualifying Certificate (Basic Science) Initiative to be Postponed: Reason, the New Registration Law of California."

Vol. 44, No. 4, April, 1936, page 252. Editorial: "Basic Science Law of State of Washington: Interesting State Supreme Court Decision."

Vol. 44, No. 4, April, 1936, page 349. Special Article: "Basic Science Act of Washington."

Vol. 45, No. 3, September, 1936, page 218. Editorial: "Qualifying Certificate (Basic Science) Legislation."

Vol. 46, No. 1, January, 1937, page 4. Editorial: "Value of Basic Science (Qualifying Certificate) Laws: as Proved by Experience."

Vol. 46, No. 4, April, 1937, page 53 (Supplement). Report of Special Committee on a Qualifying Certificate (Basic Science) Law.

Vol. 47, No. 1, July, 1937, page 3. Editorial: "Qualifying Certificate (Basic Science) Initiative."

Vol. 48, No. 4, April, 1938, page 49 (Supplement). Report of Special Committee on a Qualifying Certificate (Basic Science) Law.

Vol. 50, No. 4, April, 1939, page 53 (Supplement). Report of Special Committee on Basic Science Law.

Vol. 50, No. 6, June, 1939, page 395. Editorial: "California's Need for a Basic Science Law."

Vol. 54, No. 4, April, 1941, page 201. Report of Committee on Public Relations.

Vol. 55, No. 1, July, 1941, page 38. Council Minutes, Item 5.

Cooking of Garbage Reduces Swine Trichinosis Inspection.—The Canadian system of requiring all garbage to be cooked before being fed to hogs has established a record of less than one-twentieth of the present swine trichinosis infection in San Francisco, editorials of *The Journal of the American Medical Association* said recently.

"In Canada all garbage-feeding hog ranches are required to be licensed and inspected, and all garbage is cooked prior to feeding. The inspection includes rodent control. Recent studies reveal that swine trichinosis has been reduced to 0.2 per cent by this method," the editorial pointed out.

"As soon as it becomes 'politically feasible,' complete elimination of infected pork should be possible in American markets," the medical journal declared.

Health Director Geiger explained that numerous attempts on the part of the San Francisco Board of Health to have state legislation passed along these lines have failed due to lack of coöperation by other counties, and in some cases by opposition from the counties.

The medical journal said recent examinations of Dr. Geiger revealed that 15 per cent of 93 garbage-fed hogs offered for sale here were found to be infected with trichinosis.

"At that time the only politically feasible method of reducing this percentage was rodent control," the journal declared. "This was introduced and since then the percentage of infection of garbage-fed hogs received by San Francisco abattoirs has fallen to 4:04 per cent."—San Francisco *News.*

† In the front advertising section of *The Journal of the American Medical Association,* various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

‡ For editorial comment in this issue, see page 56.

U. C. Medical Physics Laboratory.—Ground was recently broken for the new Medical Physics Building at the University of California.

The structure will be used to exploit the new sciences developed by the atom smashing cyclotron and will house specialized laboratories for research men in many fields of science.

With the new facilities the university will be able to concentrate from ten to fifty men on a single scientific problem at one time.

Costing $165,000—the gift of an anonymous donor—the building will have 16,000 feet of floor space and will be forty-five feet wide and 160 feet long.

The laboratory will represent a union of physics and medicine and other branches of science such as chemistry, bacteriology, biology and genetics.

Primary materials will be the radioactive or radium-like substances produced in the atom smashing cyclotrons of Prof. Ernest O. Lawrence. Biological studies will be supervised by Dr. John H. Lawrence, assistant professor of medicine and brother of the Nobel Prize winner.—San Francisco *Examiner*.

Put the Doctor on a Par With Other Debtors.—The average run of citizens who take automobiles to a garage for overhauling or repairs do not expect to recover their property until they have paid the mechanic's bill. How different is their attitude towards the doctor's indebtedness!

The doctor is mechanician, engineer and all round repair man for the ailing human frame. Yet he rarely gets paid when his work is done.

According to an editorial some time ago in *America*, the Metropolitan Life Insurance Company made an interesting survey among its millions of policyholders. The survey reports that the average annual payment for the average family to its physician was $140. Only the doctor himself knows when and after what delays this sum was finally paid to him.

The commentator says wisely:

Now the cost of repairing the human machine engenders one of the most interesting problems of the day. It is a most important factor in the family budget. From very many parts of the country the report has come that, after the bill for medical services has been rendered, the family physician, who floated into the house with healing upon his angelic wings, assumes the menacing part of a Shylock.

That medical, hospital, and surgical fees do impose a terrific burden upon some families is beyond all question. To many a man working for a salary, the physician's order to go to a hospital for an operation is worse than a decree in bankruptcy. It means, in many instances, the loss of his job, and a period in which bills pile up so high that he must work for the rest of his life to pay them.

This fact is recognized by the profession. For several years medical, surgical and hospital committees have been surveying the field, and as they are animated by an honest purpose, we can rely upon an accurate and intelligent diagnosis of a very serious social problem. But it has already become apparent that the reason of many a heavy hospital bill is the fact that the patient and his family have demanded unnecessary, and even luxurious, accommodations and special service. Even when they are sick, some people never lose their ambition to keep up with the family of Jones.

One aspect of this problem should not be lost sight of. If some physicians demand, and collect, exorbitant fees, others never receive the modest fees which they ask. Every profession has its list of non-paying clients, but the physicians probably have the longest catalogue. Men who have been snatched from what Mr. Toots would designate as the Cold and Silent Tomb, are so jubilant that they are quite unable to think of anything so prosaic as a bill for professional services rendered. Besides, now that the crisis is safely passed, they are too busy arranging a trip to Europe.

Most families have a tale of the Exorbitant Physician. There is such a creature. But there is also the physician who comes home tired out after a long day, to wonder where he can scrape enough money together to meet his office rent. In his behalf, we would urge the obligation, sanctioned by all law, human and divine, to pay one's debts as promptly as possible.

W. L. Halverson, M. D., Appointed Health Officer of Los Angeles County.—Dr. W. L. Halverson of Pasadena recently was appointed by the county board of supervisors as Los Angeles County health officer, a job which pays $6,300 per year.

A Pasadena city health officer, Doctor Halverson, with a grade of 92.28, headed a list of seven applicants who recently took the civil service examination for the position.

The job was made vacant by the death of Dr. John Pomeroy.—Los Angeles, *The News*.

Sulfa Drugs.—Chicago (Science Service).—One of the new sulfa drugs, sulfadiazine, is as effective in pneumonia and other similar infections as the best of the older chemical treatments, but with less discomfort due to the treatment, three Boston physicians, Dr. Maxwell Finland, Elias Strauss, and Osler L. Peterson, have reported to *The Journal of the American Medical Association*.

Toxic effects were relatively mild and infrequent, only 9.2 per cent becoming nauseated.

Sulfadiazine was used in the treatment of 446 patients with various infections. It appeared to be highly effective in the treatment of the following diseases: pneumococcic, staphylococcic and streptococcic pneumonias; meningococcic infections; acute infection of the upper respiratory tract including sinusitis; erysipelas; acute infections of the urinary tract, particularly those associated with Escherichia coli bacilluria, and acute gonorrheal arthritis.—Pasadena *Star-News*.

Infantile Paralysis.—Scientists are being forced to the conclusion the entry of infantile paralysis virus in man, Dr. E. W. Schultz of Stanford University said recently, is not through the nasal mucous tissue.

He told the Association for the Advancement of Science, Pacific division, that rapidly growing evidence indicates the common point of entry to the nervous system may be either the mucous surfaces of the pharnyx or the intestinal tract, or both, according to an Associated Press dispatch.

"Few diseases have yielded more slowly to scientific analysis than has poliomyelitis," said Dr. Schultz. "After more than a quarter of a century of research we still lack the fundamental knowledge necessary to suggest a practical measure for its control.

"Our knowledge of this disease is advancing, but until the natural portal of entry is definitely known and the pathogenesis of the disease is more clearly understood, it seems unlikely that a truly practical measure will suggest itself for poliomyelitis control."—Palo Alto *Times*.

San Francisco Blood Bank.—San Francisco's blood bank is ready to receive blood from twenty-five to thirty donors a day.

That announcement came from Dr. D. K. Burnham, chairman of the Blood Bank Commission of the San Francisco County Medical Society, as he issued a call for donor volunteers.

The commission hopes, he explained, to build up a blood bank adequate to meet all San Francisco's needs, as well as aiding the needs of America's armed forces and, perhaps, giving some help to England.

Prospective donors are requested to telephone the blood bank at WAlnut 5600, 2180 Washington Street, for appointments, and for instruction as to diet restrictions during the hours preceding the giving of blood.

Doctors and nurses will receive donors between the hours of 9 a. m. and 3 p. m., Mondays through Fridays, with an additional period to 7:30 p. m. Wednesdays, and from 10 a. m. to 4 p. m. on alternate Saturdays, beginning the coming weekend.—San Francisco *Examiner*.

The American Board of Pediatrics, Inc.—There will be an oral examination for certification by the American Board of Pediatrics in Los Angeles, California, at the time of the Region IV meeting of the American Academy of Pediatrics, which will probably be in May, 1942. Written examination, for the candidates intending to take the oral in Los Angeles, will be held locally, under a Monitor, approximately six weeks prior to the date of the oral examinations.

For further information, address 707 Fullerton Avenue, Chicago, Illinois.

The Doctor As a Citizen*.—Physicians, it is sometimes charged, show scant interest in the cultural life of the community. Time was when the doctor, like the clergyman or the teacher, was a civic leader whose opinions on art, politics, or philosophy were eagerly sought. In reviewing the history of The Medical Society of New Jersey, one notes, for example, that the eighteenth century physician was often a mayor, an alderman, or a congressman; and always an active, public-spirited citizen.

Today's complaint is that doctors are too narrow. "Whenever M. D.'s get together," runs one grievance, "they talk of nothing but medicine." We do not know how true that is, but we do know that, if physicians lose touch with wide civic problems, it will threaten their prestige, and ultimately lead to their classification as plodding technicians.

Two possible remedies may be suggested:

1. Let medical societies—county or private—more often listen to non-medical speakers on community questions.

2. Let medical organizations more actively participate in civic affairs.

Thus, the Society of Surgeons last month, under the leadership of Dr. Sprague, invited Eric Sevareid to discuss the current European situation. Here was a thought-provoking, non-medical talk topping off a full day of surgical demonstrations and scientific papers. It set up a healthy ferment of fresh discussion, and served notice that we doctors are citizens with a tremendous stake in the community. We demonstrated an intelligent interest in the body-politic as well as in the body-biologic.

Your Public Relations Committee furnishes medical speakers to non-medical groups. We doctors address bankers and barbers, lawyers and laymen, teachers and typists; and yet we seldom ask non-medical speakers to tell *us* anything about non-medical subjects. Why not?

Participation, furthermore, should be active as well as passive. It is good to see the Academy of Medicine of Northern New Jersey co-sponsor the Town Hall—and not just the Lahey meeting, but also the forums at which such varied authorities as Erika Mann, Eve Curie, and Clifton Fadiman spoke. The Academy, one of a select list of participating civic organizations, announced in effect that doctors are citizens, too. In varying scale, this kind of participation is open to any medical organization. Any county society or private medical club can co-sponsor a civic activity to its own great advantage as well as that of the community.

To win public admiration for our scientific skills is not enough—we must also win respect as *citizens*. If we ignore the welfare and cultural activities of the community, we brand ourselves as civically irresponsible medical mechanics. By plunging into the intellectual life of the community, we can earn a solid place in the minds and hearts of our fellow-citizens.

A century ago, a passer-by tipped his hat as he greeted the doctor in the street. We do not ask for such outward symbols today. But we do want the affection and respect which that hat-tipping implied; and we will get it if we earn it.— Charles M. Robbins, M. D., Chairman, Public Relations Committee.

* From the *Jour. Med. Soc., N. J.*, March, 1941.

Electron Microscope: Gift to Stanford.—Further pursuit of the tiny electron and development of a microscope to make the individual molecules visible, have been launched by Stanford University.

President Ray Lyman Wilbur has announced receipt of a gift of $65,000 from the Rockefeller Foundation to finance a five-year program of research by students of the electron.

The university has chosen Dr. L. Marton, 40-year-old Hungarian physicist, to head the program. He designed and constructed the first biological electron microscopes in Europe and the United States. He will come to Stanford in September as an associate professor.

Doctor Wilbur stated the grant will enable Stanford to lead in improving and adapting the electron microscope to research in biology, bacteriology, chemistry, physics, metallurgy and medicine.

Sulfadiazine: Statement by Perrin H. Long of Johns Hopkins.—News dispatches from San Diego on July 22, contained the following story:

A remarkable new derivative of the "miracle drug," sulfanilamide, soon will be available in the battle being fought with increasing success against infectious diseases.

That was disclosed here today by Dr. Perrin H. Long, professor of preventive medicine at Johns Hopkins University, Baltimore, under whose direction research on sulfanilamide was conducted at the institution.

On Market by Fall:

The new drug is sulfadiazine, effective in nearly all germ ailments and applicable to nearly all patients without the unfavorable results that often attend the use of other sulfanilamide derivatives, Dr. Long declared.

Now being tested by the United States Food and Drug Administration, sulfadiazine probably will be on the market by early fall, he asserted.

Toll Reduced:

"I have good reason to believe it will supplant all sulfa drugs now being used," Dr. Long said. He pointed out that these new medicines during the last five years have brought about a marked decrease of the death rate in infectious diseases, a fact most dramatically shown in Army mobilization of the present emergency.

"During World War I, 58,000 men died of disease, as against 50,000 who succumbed on the battlefield or died of wounds.

Army Deaths:

"Percentage of fatalities from diseases was extremely high as compared with that in today's army camps. Pneumonia deaths were 35 per cent of those who contracted the disease; today they run only 2 per cent; spinal meningitis has dropped from 38 per cent to 5 per cent mortality; there is practically no record of influenza deaths nor of fatal streptococcal infections in the Army today.

Other Treatments:

"This is in spite of epidemics of influenza, measles, pneumonia and cases of meningitis which occurred as mobilization got under way in the current emergency. The major reason for this improvement is use of sulfanilimide, sulfapyridine and sulfathiazole.

"In addition to curing hitherto fatal infections, these drugs have markedly improved the treatment of gonorrhea, cause of loss of 7,000,000 man days in the last war."

The Danger of Flying Glass in Air Raids.—The amount of broken glass from windows shattered by the blast of high explosive bombs in this country must run into many thousands of tons. The flying glass is exceedingly dangerous, as it cuts like a knife. A wide range of material is now available for protection against flying glass and for use as a substitute for glass. At an exhibition held in London, not fewer than eighty substitutes for glass were shown. They are weatherproof and can be fixed to metal frames by a special composition.—*London Letter.*

LETTERS†

Concerning Terms. "Health Insurance" versus "Sickness Insurance"*

January 17, 1941.

To the Editor:—The term "Health Insurance" has been challenged as fallacious and misleading. In order that there be no misunderstanding as to the intent and meaning of the phrase, we should properly investigate its use and definition and compare it with the proposed term "Sickness Insurance" . . .

Therefore, by definition, meaning, and common usage, the term "Health Insurance" is accurate, honest, and legitimate.

Very truly yours,
ELINOR B. HARVEY.
DONALD K. FREEDMAN.

Reply

January 20, 1941.

To the Editor:—Inexact terms and lack of definitions are common causes of profitless controversy and confusion of thought. If the medical profession is to continue to deal honestly within its own ranks and with the public, it will wish to use terms that are neither ambiguous nor deceptive.

There is much to be said in favor of insurance to meet the cost of medical care in sickness especially if on a voluntary basis. If such insurance is sold to the public as "Health Insurance" the insured will expect health which cannot be promised or paid for on any basis so far undertaken. The first step toward useful discussion is a correct use of terms.

1. Fire Insurance, Accident Insurance, Burglary Insurance, Sickness Insurance are terms implying financial protection against the costs of the hazard named.

Life insurance is an investment in benefits to others than the insured person, who pays for them during his life.

Sickness insurance, a term correctly describing systems, voluntary and compulsory, in effect in continental Europe at least since Bismarck's time, was replaced in England for political persuasiveness by Lloyd George about 1912 to obtain support for his compulsory participating plan for medical care for wage earners. The term "Health Insurance" is widely used in this country for the same purpose. Neither the purpose, which is to persuade people to vote for something they will not in fact receive, nor the term itself as descriptive of the purpose for which the insurance fund is created, justifies our use of the phrase "Health Insurance" in medical discussions among ourselves or with the laity, except to warn against its incorrect and unpredictable implications.

2. Group or individual insurance to meet the cost of periodic medical or health examinations or examinations for diagnosis and early treatment of "pre-clinical" states of disease may or may not contribute to the health of the individual, according to the patient's understanding and coöperative ambition to achieve, maintain, or improve his health. This cannot be insured either for or against. This is not included among compulsory "Health Insurance" benefits in England. There is no evidence in this country or abroad that insurance schemes to meet the cost of care in sickness have been an important factor in the health status of the people generally or of the insured group. Nor has the misnamed "Health Insurance" scheme in England brought to the insured a superior or adequate quality and range of medical care in sickness.

3. Sickness insurance will win its way into dictionaries and ultimately in the *Index Medicus* when it is clearly understood to describe something definite, exact, correct as defined, and quite different from "Health Insurance" as intended by its current promoters.

Whatever our language or national inclinations or traditions, we must admit that *Krankheit Versicherung* has the precise meaning of sickness insurance. *Gesundheit Versicherung* is something different and nonexistent. The British adopted a new name for an old thing without altering its essence or quality.

There are no health services offered or provided for under the "Health Insurance" scheme in England. Insurance is not paid when health is lost. The cost of sickness is paid for. The insured determines when he or she is sick and demands attention. The insured have no investment in health and their insurance does not give them any better health.

Very truly yours,
HAVEN EMERSON, M. D.

Concerning California Law Applying to Graduates of Foreign Medical Schools

(COPY)

STATE OF CALIFORNIA
LEGAL DEPARTMENT

San Francisco, July 14, 1941.

Board of Medical Examiners,
515 Van Ness Avenue,
San Francisco, California.

Attention: Charles B. Pinkham, M. D.
Secretary-Treasurer.

Gentlemen:

This is in response to your request of June 27, 1941, in which you propound a series of questions concerning the application of the recent amendment to Business and Professions Code Section 2193 (Stats. 1941, Chap. 751) to become effective September 14, 1941.

As pointed out in opinion NS3403, addressed to you under date of April 4, 1941, the amendment adds a fifth condition or requirement of licensure to the present four conditions or requirements which must be met with respect to all applications for a physician's and surgeon's license, which applications are based upon diplomas issued to the applicants by foreign medical schools approved by your Board, except Canadian schools. This new condition, identified as Subdivision (e) of Business and Professions Code, Section 2193, provides, in effect, that such applicant, if he is not a citizen of the United States, may be permitted to take the physician's and surgeon's examination given by your Board only if the foreign country in which he has been licensed to practice will admit to practice therein citizens of the United States, upon proof of prior admission to practice medicine and surgery in some State of the United States.

Section 2 of the amendment reads as follows:

Subdivision (e) added to Section 2193 of the Business and Professions Code by this amendatory act does not apply to any person who on March 31, 1941, was registered as an interne under Chapter 5 of Division 2 of the Business and Professions Code, relating to the practice of medicine.

I*

Your first question reads as follows:

What is the status of the foreign medical school graduate who has filed our Form 172-173 and thereby has "registered" in conformance with the rules of the Board of Medical Examiners, but who has not prior to March 31, 1941, *commenced* the one year interneship training required under Section 2193, Subdivision (d)?

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

* From the New York State *Journal of Medicine*. This controversy began with the publishing of Dr. Haven Emerson's letter in the January 1 issue—Editor. For editorial comment in this issue on "Sickness and Health Insurance," see page 56.

* Numerals inserted by the Editor for convenience in reference.

It is my opinion that it is not necessary that the applicant have actually commenced serving his interneship prior to March 31, 1941, so long as he has duly executed and filed with you your form 172-173. Said form, on its face, clearly indicates that its purpose is to serve as a preliminary registration by graduates of foreign medical schools whose credentials have yet to be approved by your Board and who, following such approval, will be required, and propose, to complete either the senior or fourth or final year in approved medical schools in the United States, or, in lieu of this, serve at least one year in residence in hospitals located in the United States and approved by the Board for training of internes.

There is nothing in Chapter 5 of Division 2 of the Business and Professions Code providing for either the time or mechanics of registering as an interne. In adopting Section 2 of the recent amendment, supra, the legislature undoubtedly had in mind the practice of your Board in requiring that such registration on your form 172-173 be filed *prior to commencement of the interneship.* A recognition and adoption of this practice is apparent from the language of Section 2 of the amendment, supra, for had the legislature intended to require the actual commencement of interneship by March 31, 1941, as a condition of eligibility for admittance to examination, it could, and undoubtedly would, have used the word "commence" rather than "registered."

II

Your second question reads as follows:

What is the status of the foreign medical school graduate who has filed our Form 172-173 and who has received notice from some approved hospital in the United States that he has been accepted as an interne for service commencing July 1, 1941?

As pointed out above, it is not a question of time of commencement of interneship, but rather of registering as an interne with you, which the applicant does upon filing your Form 172-173. Therefore, an applicant such as you describe in your second question is not affected by the amendment if he filed said form with you on or before March 31, 1941.

III

Your third question reads as follows:

What is the status of the individual who has filed our Form 172-173 and who, on March 31, 1941, was interning at an approved hospital, who thereafter transferred to another approved hospital where he intends to complete the *entire* one year interneship under Section 2193, Subdivision (d)?

I do not believe that his transfer from one hospital to another works any change with respect to his registration as an interne within the contemplation of Section 2 of the amendment. Neither said Section 2 nor your Form 172-173 in use at the time of the adoption of said amendment, makes any reference to commencement of interneship or change of status with respect thereto.

Here, as in the situation described and discussed in connection with your first and second questions, the determining factor is the date of filing your Form 172-173.

IV

Your fourth question reads as follows:

Assembly Bill 1475 (Chapter 751) requires that the country in which the foreign medical school graduate (an alien) is licensed shall grant the same privileges to a citizen of the United States as are exacted under the laws of this state in connection with a license to practice medicine and surgery. We assume that the phraseology in Section 2193, Subdivision (e) means that the Board of Medical Examiners of California must be furnished with satisfactory evidence that the foreign country in which the applicant is licensed, granted the same privileges to American citizens at the time the applicant's medical license was issued.

I do not agree with your assumption. In my opinion, Subdivision (e) of Business and Professions Code Section 2193 requires only that the so-called similar privileges be accorded citizens of the United States by the foreign country in question *at the time that the foreign applicant makes application to your Board,* rather than that such similar privileges shall have been granted by said foreign country at the time the applicant in question was admitted to practice therein.

In support of this view, I direct your attention to the language of said Subdivision (e), which is in the future, rather than past, tense. The subdivision reads as follows:

If the applicant is not a citizen of the United States, the country in which he has been licensed to practice medicine and surgery *will admit to practice* therein citizens of the United States upon proof of prior admission to practice medicine and surgery in some State of the United States or upon proof of matters similar to those required in this section for graduates of foreign medical schools. (Italics supplied.)

V

Your fifth question is as to the type of proof which the Board should require of applicants with respect to the laws of the country in which they are licensed.

In answer thereto, I respectfully direct your attention to opinion NS3403, wherein this office stated:

Evidence offered in the manner provided by either of the following code sections would be competent as to the laws of the particular foreign country upon the subject.

"Books printed or published under the authority of a sister state or foreign country, and purporting to contain the statutes, code, or other written law of such state or country, or proved to be commonly admitted in the tribunals of such state or country as evidence of the written law thereof, are admissible in this state as evidence of such law."

Code of Civil Procedure, Section 1900.

"A copy of the written law or other public writing of any state or country, attested by the certificate of the officer having charge of the original, under the public seal of the state or country, is admissible as evidence of such law or writing."

Code of Civil Procedure, Section 1901.

In addition, or in lieu thereof, it would be proper, in my opinion, for your Board to accept evidence in the form suggested by you, viz:

(a) Over the seal and signature of the local consul of the country in which the individual was licensed;

(b) Over the seal and signature of the American consul in the country in which the applicant was licensed.

VI

Your sixth question reads as follows:

Will a foreign medical school graduate (not a citizen of the United States) who is granted a medical diploma by an approved medical school in the United States, be entitled on the basis of said diploma to file application for and be admitted to a written examination for a physician and surgeon certificate in California?

If that could be done, then the provisions of Business and Professions Code Section 2193 (covering applications based on diplomas from foreign medical schools) could be nullified with respect to every foreign school graduate who, in observing Subdivision (d) of said section, secures admittance to the fourth or senior year in an approved school in the United States, completes said year of study, receives a diploma from said school, and offers same, rather than his foreign school diploma, as the basis of his application. In other words, we would have the anomalous situation of a foreign school graduate seeking to qualify under Business and Professions Code Section 2193 and then by virtue of the very act of qualifying thereunder removing himself from the other provisions of said section. For this reason it is my opinion that a so-called diploma issued by a medical school in this country, based upon studies largely completed in a foreign school and only partially completed in this country, would not be sufficient to take the case out of the provisions of Business and Professions Code Section 2193. Such applicant must present both his foreign medical school diploma and his diploma or certificate from an American medical school.

If the subdivision be construed in this way, it has a reasonable and just application and more fully accords with the intention of the legislature. The legislative intent will

control a literal construction which leads to injustice and absurdity. "A statute may be construed contrary to its literal meaning when a literal construction would result in an absurdity or inconsistency."

Leo v. *Board of Medical Examiners*, 36 Cal. App. (2d) 490, 493.

This result would not obtain, however, if one who graduated from a foreign medical school chooses to disregard his diploma from said school and the work completed therein and to start his medical education anew in this country, completing in a school or schools in this country the full residence course required for a diploma, and thereafter make said diploma the basis for his application.

VII

Your seventh question reads as follows:

We assume your opinion on the above will hold in the instance of a foreign medical school graduate licensed in another state who seeks a California reciprocity certificate.

Business and Professions Code Section 2316, on the subject of reciprocity, reads as follows:

He shall inform the board on his application form of all institutions from which he has graduated and of all institutions at which he has studied and the period of this study.

The requirements of the college from which he has graduated *and the requirements of the medical licensing authority shall not have been at the time his certificate was issued in any degree or particular less than those which were required for the issuance of a similar certificate to practice a system or mode of treating the sick or afflicted in this State at the same time.* (Italics supplied.)

By virtue of the italicized language of said code section, it is my opinion that a graduate of a foreign medical school who applies for reciprocity in California, based on a certificate issued to him in another state after the adoption of Business and Professions Code Section 2193 (originally Stats. 1913, p. 722) or the date of the adoption of the applicable amendments thereto, is not entitled to such reciprocity unless the state whose certificate he uses as the basis of his reciprocity application had a statute similar to Business and Professions Code Section 2193 at the time he was admitted to practice in said State and the applicant had met the requirements of said statute in securing admittance to practice therein.

Very truly yours,

EARL WARREN,
Attorney General.

By THOMAS COAKLEY,
Deputy.

Concerning the California Regional Fracture Committee of the American College of Surgeons.

To the Editor:—The American College of Surgeons realizing that in some instances patients suffering fractures of the extremities and back have been inadequately treated, has therefore appointed fracture committees in every State of the Union.

The purpose of these committees is to help educate the medical profession in order that better first-aid treatment might be given to the injured. Better results are obtained when the injured extremity is immediately placed in traction using the Thomas type of splint with bandage or cloth traction applied over the shoe if necessary. The ambulances in incorporated cities now carry Thomas splints as part of their first aid equipment. They also have stretchers with a pillow which will prevent angulation and possible spinal cord injury in those patients suffering fractures of the spine. The patient then should be speedily transported to an approved hospital wherein the accepted type of x-ray examination is performed. The College is desirous of having all hospitals, which accept fracture cases, be equipped with fracture beds, Balkan frames, suitable apparatus for weighted traction, and the usual apparatus for skeletal traction.

Organized hospital staff conferences should be given at least once a year by men particularly interested in fractures and the entire evening should be devoted to the proper care of the injured. All patients suffering with serious fractures should have a consultation with a doctor particularly skilled in the treatment of fractures and adequate progress notes should be filed with the patient's chart.

California, being a large State, has two fracture committees, the centers being San Francisco and Los Angeles. The members of these committees are willing to enter into consultation with the attending physician and if necessary to give their services gratuitously. If all of these ideas are continuously carried out in California, better end results will be obtained in the injured.

The Committee for Southern California is as follows:

Los Angeles

Frank J. Breslin, Los Angeles, Chairman.
Francis M. McKeever, Los Angeles, Secretary.
William Arthur Clark, Pasadena.
John Ball, Santa Ana.
Harold D. Barnard, Los Angeles.
Philip J. Cunnane, Los Angeles.
Wallace Dodge, Los Angeles.
Clyde E. Early, Los Angeles.
Charles Phillips, Los Angeles.
Harry Schurmeier, Santa Barbara.
Arthur L. Weber, Upland.
Robert W. Wilcox, Long Beach.
John C. Wilson, Los Angeles.
Benjamin M. Frees, Los Angeles.
Alfred E. Gallant, Los Angeles.

San Diego

Maynard C. Harding, San Diego, Chairman.
Paul R. Brust, San Diego.
Elmo G. Crabtree, San Diego.
Ralph Kaysen, San Diego.
Fraser L. MacPherson, San Diego.
Louis Strahlman, San Diego.

San Francisco

Lt. Col. N. T. Kirk, San Francisco, Chairman.
Frederic C. Bost, San Francisco.

Sincerely yours,

FRANK J. BRESLIN, M. D., *Chairman,*
The Regional Fracture Committee
The American College of Surgeons.

Concerning Rheumatic Heart Disease*

SAN FRANCISCO MEDICAL SCHOOL

March 25, 1941.

To the Editor:

On December 27, 1940, Dr. Howard F. West sent me the following letter:

"By postcard ballot the Executive Committee of the California Heart Association has unanimously voted to submit to the State Board of Health a recommendation that rheumatic heart disease be made a reportable disease. I am enclosing a formal statement to that effect.

"I would like to appoint you as a committee of one to draft a definition of rheumatic fever that you think would be appropriate to accompany this request. Of course, you may consult with any of the San Francisco men whom you may desire."

It seemed important to me that before making rheumatic fever a reportable disease, considerable education might advantageously be carried on in the JOURNAL of the California Medical Association. I made this proposal, and have been delegated to approach Doctor Kress with this in mind, so he may make editorial comments to a point where the profession will be willing to accept the fact that the

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* For editorial comment, see page 58.

California Heart Association desires rheumatic fever to be a reportable disease.

Concerning the definition which Doctor West wishes me to write, I quote the following:

Rheumatic fever is probably due to an infectious agent which causes polyarthritis when it affects the joints, chorea when it attacks the brain, and rheumatic heart disease when it involves the heart. Rheumatic heart disease should be regarded as one of the manifestations of rheumatic fever, not as a complication. Tonsillitis or upper respiratory tract infection often associated with hemolytic streptococci, muscle pains or growing pains, toritollis, purpura, various erythemata and subcutaneous nodules, may be accepted as evidences of rheumatic fever. Especially in childhood the only symptoms indicative of rheumatism may be recurrent attacks of unexplained fever, secondary anemia and a state of poor general health, with lassitude and retarded growth.

These rheumatic manifestations may occur singly or in various combinations, and are of varying duration. The heart is often involved simultaneously with these manifestations or just following them, or evidence of involvement may be lacking for months or years. The heart is, in other cases, the first and apparently the only structure involved, so that rheumatic heart disease may occur without any other manifestation of rheumatic fever.

Rheumatic heart disease may be active or inactive. The term carditis is used loosely to denote acute pericarditis, myocarditis, or endocarditis, separately or in combination.*

Will you please give me your opinion on this before I ask Doctor Kress to give it the desired publicity?

Sincerely yours,

(Signed) Amos Christie, M. D.

* Quotation from: *Nomenclature and Criteria for Diagnosis of Diseases of the Heart* by the Criteria Committee of the New York Heart Association, New York, 1939.

Courses for Graduates in Medicine*

Stanford University School of Medicine
2398 Sacramento Street
San Francisco, California

July 18, 1941.

To the Editor:

Stanford University School of Medicine announces a series of Postgraduate Courses in Medicine, to be given at the Stanford Medical School in San Francisco, September 8 to 12, 1941, inclusive.

These courses are designed primarily for practicing physicians and are of the review or refresher type. Intensive instruction covering physiology, pathology, diagnostic procedures, as well as therapy, will be given by the Medical School Faculty in each one of the courses offered.

I am enclosing an announcement of the 1941 courses and I hope that you will be able to publish this in California and Western Medicine.* Thanking you for your cooperation, I remain,

Very truly yours,

(Signed) L. R. Chandler, M. D., *Dean.*

Criteria of Death and Signs Indicating Same.

City and County of San Francisco
Department of Public Health

July 22, 1941.

To the Editor:—Attached is a copy of an Executive Order of this department entitled *Criteria of Death and Signs Indicating Same* which I thought would be of interest.

Sincerely,

(Signed) J. C. Geiger, M. D.
Director.

101 Grove Street.

(copy)

Executive Order No. 250

Criteria of Death and Signs Indicating Same

After a conference between the Chief Surgeon of the Emergency Hospital Service of the Department of Public Health and the Coroner, criteria indicating death have been agreed upon. Therefore, the following signs are to be looked for and checked carefully in every case of death in the institutions of the Department of Public Health. It is mandatory that these signs be checked completely in every case in which a patient is pronounced dead.

1.—Cessation of respiration as determined by: (a) The stethoscope against the larynx; (b) Holding a mirror in front of the nose to note condensation of moisture; (c) Movement of air currents against wisps of cotton placed in the nose.

2.—Cessation of heart beat as indicated by testing with the use of a stethoscope placed on the precordium.

3.—Cessation of circulation as evidenced by: (a) Opacity of the hands when held up to a bright light; (b) Failure of a bleb to appear on the skin after direct application of burning heat; (c) Lividity and dependent discoloration.

4.—Loss of body heat.

5.—Rigor mortis.

6.—Coarsening of the texture of the conjunctiva (this is not a perfectly reliable sign and neither is the state of the pupil).

7.—Body decomposition.

J. C. Geiger, M. D.
Director of Public Health.

Sterilization of Criminals.

To the Editor:—"Birth control, sterilization of criminals and the unfit, and 'mercy killings' demand the 'initiative and direction of medical science' as a means of checking human degeneration."

The above is an utterance of Earnest A. Hooton, professor of anthropology of Harvard University. Mercy killings, or enthanasia as it is scientifically called, is a long way in the offing.

This writer would never give consent to such drastic measures to eliminate the unfit. Every one so unfortunate as to be born into this world with any hereditary degeneracy should receive such care and comfort as is reasonably humane, but common sense teaches that they should not be allowed to bring others into the world to be a misery to themselves and a further burden to society.

The above question is interesting, as it shows the trend of thinking on this all-important subject. It seems strange that so many people, good Christians having the welfare of mankind at heart, will do all they can to relieve the sufferings of these people, but will oppose the most fundamental and practical method of preventing their misery and suffering.

For many years the medical profession devoted all its talents to relieving or curing the physical suffering of mankind, but with advanced knowledge they found prevention better than cure, and as a result preventive medicine has become a very important part of the medical curriculum. When society learns that much degeneracy that now obtains is hereditary and is an amenable to prevention as are many diseases, and that an intelligent application of the principles of eugenics will accomplish this, much of the objection now prevailing will disappear.

The church should take the lead in promoting an eugenics program to reduce the number of degenerates in society, and thus formulate a program more in keeping with the principles of the church than is likely to be in a program promoted by those who have no interest in the church. Such a program would not interfere with any philanthropy needed to take care of all the needs of the present, and would reduce the amount of misery and suffering of the next generation, relieve society of a heavy burden, and allow for more effort to be devoted to purely religious matters.

Eugene H. Pitts, M. D.

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* For program of courses, see under Committee on Postgraduate Activities, on page 98.

Concerning Presentation of Medical Topics in Newspapers.

New York, July 26, 1941.

To the Editor:

Here is a copy of a letter which I have written to Dr. Robert N. Nye of the *New England Journal of Medicine,* in supplement to a July 17 editorial of his. The points we both raise will surely interest readers of California and Western Medicine, and editors of lay publications whom you deal with.

Now that I am writing you again, let me remark that California and Western Medicine no longer comes to me, probably because I no longer am with *Time* magazine. And probably because you do not know that I am consultant editor on medical and science news to various organizations. I must read so many publications that usually I welcome the loss of one. Yet I do miss California and Western Medicine, which I consider among the four best medical journals on this continent. So I wish you would return me to your mailing list.

With best regards,

Sincerely,
(Signed) Myron Weiss.

* * *

New York, July 26, 1941.

Dear Doctor Nye:

Greetings.

Your July 17 editorial on "Popularization of Science" deserves widespread reading and a sound follow-up.

The fault for exaggerating medical news in this case is not entirely that of *Science News Letter,* or of the American Medical Association's editorial department who prepared the news releases (summaries for newspapers) of papers read at the Cleveland convention. Their rewrites and interpretations are always competent.

Now does the fault lie with the demand of newspapers for exciting articles? Editors now know that the laity is eager to read medicine news presented to them soberly and accurately. I demonstrated this the many years I was associate editor of *Time* magazine. To show that the same sober and accurate treatment would hold readers of daily papers I published similar medicine news articles in the Boston *Transcript* and Miami *Herald* last year.

The fault for inaccurate medical reporting in lay publications lies in many other directions. In the first place, few writers of medical papers know how to put their thoughts and observations down in clear English, even in clear medical jargon.

Next, there are very few science writers in this country informed enough to translate medical news for the laity. At conventions these few have so much work to do that it is impossible for them to apply their critical faculties to every detail offered them, or to get quick confirmation from medical authorities at the convention. They, perforce, must depend upon the press releases handed to them. They hurriedly liven these up with a few phrases and send them to their newspapers. The newspaper editors, in their hurry, presume that everything reported at a medical convention is brand new. They then may add some exciting phrases or a mistaken headline.

You caught *Science News Letter* in a rare fumble. More such faulty reporting will occur now that our medical societies are hiring publicity agents to protect their causes. Such publicity agents tend to become the go-betweens of the medical and newspaper professions. However, doctors rarely trust the common sense of their publicity employees, and few publicity men know enough about medicine (its art, science and ethics) to warrant the confidence of their medical employers.

All this trouble, thus, comes down to a complex lack of knowledge and alertness—but not a lack of conscientiousness—all around.

A sound preventive of such trouble would be for medical organizations to employ special editorial counsel. Such counsel would be able to instruct routine writers on the one hand and on the other to protect the organization from unwise publicity.

Another difficulty now arises. The technique, the knowledge and the philosophy for such editorial counseling of our medical profession is very rare. Yet it is available.

With best regards,

Sincerely,
(Signed) Myron Weiss.

Editorial item in *The New England Journal of Medicine* follows:

POPULARIZATION OF ADVANCES IN MEDICINE

The June 14 issue of *Science News Letter,* a weekly publication devoted to popularized accounts of advances in the sciences, makes the following startling introductory statement concerning papers presented at the Cleveland meeting of the American Medical Association: *"Six new successful treatments, promising relief or cure for the suffering of thousands of men and women, were reported. . . . Hundred per cent control of gonorrhea is made possible by sulfa drug. Crude liver extract is the new remedy for gout and arthritis. Salts of gold are being tried secretly on human rheumatism patients. Sex hormone treatment gives new hope for those with cancer of prostate gland. Iodized oil helps sinus disease, and x-rays are advised for Hodgkin's disease."* As one reads the subsequent paragraphs, one is told that the drug, sulfathiazole, has been responsible for 100 per cent cures of gonorrhea in three days; that the use of crude liver extract in the treatment of patients with gout and arthritis was promptly followed by a disappearance of symptoms, particularly in the former disease; that a gold compound, calcium aurothiomalate, has been successfully used in the treatment of experimentally produced arthritis in mice; that female sex hormones or castration inhibits the growth of cancer of the prostate; that the injections of iodized oil into the sinuses result in the subjective improvement of patients suffering from sinusitis; and that patients with Hodgkin's disease are relieved by x-ray or radium treatment.

In commenting on these abstracts, the medically trained writer could reasonably state that sulfathiazole is a standard accepted remedy for gonorrhea, although no one has ever before obtained 100 per cent effectiveness, a claim that requires careful follow-up studies over a period of months or years; that in judging the value of any new treatment for gout,—the present treatment is reasonably satisfactory,—the possibility of spontaneous remissions of the disease must be excluded; that experimentally produced arthritis in mice is undoubtedly a different disease from human arthritis, the cause of which is unknown; that the efficacy of the use of female sex hormones in the treatment of cancer of the prostate has been discussed, pro and con, for several years; that subjective improvement in patients with sinusitis is a poor yardstick for measuring the value of any therapeutic agents; and that x-rays and radium have been used for the treatment of patients with Hodgkin's disease for several decades. In other words, three of these "new, successful treatments" have been previously reported, two require confirmation of their value, and for one no claim for efficacy in human beings has been made. Undoubtedly many, if not all, of these points were brought out by the speakers at the meeting, and it is unfortunate that popularized reports in periodicals and newspapers are, in many instances, so garbled.

The public should, of course, be informed concerning advances in medicine, since lay education of this sort is one, if not the most effective, means of promoting the health of the nation. However, such reports, particularly those in regard to widespread diseases such as gonorrhea, arthritis and sinusitis, should be accurate and conservative; if "successful remedies" are announced year after year, the layman will become suspicious, and lay support of the medical profession—a matter of vital importance at the moment—will be weakened.

MEDICAL EPONYM

Friedreich's Ataxia

"Ueber degenerative Atrophie der spinalen Hinterstränge [Degenerative Atrophy of the Posterior Spinal Columns]" was described by Professor Nikolaus Friedreich (1825-1882), of Heidelberg, in *Virchow's Archiv für pathologische Anatomie und Physiologie und für klinische Medicin* (26:391-419, 433-459, 1863). He concludes a series of detailed case reports with observations on this condition. A portion of the translation follows:

> There is a chronic inflammatory degeneration of the spinal cord that leads to atrophy, and that seems to develop especially in puberty as the result of some hereditary tendency. This is essentially confined to the posterior column, begins in the lumbar portion of the cord, progressing both upward and downward and limited by the elongation of the cord only after involving the origin and roots of the hypoglossal nerves. The affection is characterized clinically by a very gradually developing disturbance of association and harmony of movements, which progresses upward from the lower half of the body, always finally involving the organs of speech. There is complete integrity of the organs of sensation and cerebral function.—R. W. B. in *New England Journal of Medicine,* January 16, 1941.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XIV, No. 8, August, 1916

From Some Editorial Notes:

X-Ray Plates and Negligence.—Some time ago, when the House of Delegates of the State Society wisely made the rule that the Society would not defend a member in an action for damages for alleged malpractice against him, when, in the nature of the case, an x-ray plate should have been taken and kept, and was not so taken and kept, the JOURNAL published some items to the effect that before very long courts would consider it negligence not to take such plates. The truth of that prophecy is being made manifest very rapidly. . . .

Quite recently one of our members here in California was obliged to defend a suit against him at his own expense, because he could not, or would not, offer any explanation of why he had not taken an x-ray plate.

* * *

Social Insurance: Excerpts from a Letter.

To Members of the State Medical Society:

Dr. I. M. Rubinow, the author of "Social Insurance," who has come to California to assist in the work of the Social Insurance Commission appointed by Governor Johnson, met with the latter commission and with our committee on July 8. Those present besides Doctor Rubinow were Miss Katherine Felton, Mrs. Frances Noel, Mr. George Dunlop, Dr. Flora W. Smith, Miss Barbara Nachtrieb, and Doctors Sherman, Reinle, Gundrum, Tucker and Bine, representing our committee; Doctors P. M. Jones and Morton Gibbons. That there is a great deal of work to be done, many statistics to be compiled, and much to be discussed, can readily be imagined. This meeting lasted for four hours, and the discussions showed us how few actual facts pertaining to California conditions are now available.

It will be necessary for us, in our study of sickness and of health insurance in this State, to get at certain figures. They are not only essential to us for our study; they are essential to you, for your protection, should the State eventually decide in favor of social insurance. There is no reason why the same methods should be enforced with health as have been applied with accident insurance. With the accident compensation the lowest possible premiums are charged, so as to make the scheme attractive to employers. After deducting for administration, cash benefits to the injured, and, in the case of private companies, for dividends to stockholders, the question of paying the doctor comes up. He gets what is left. . . .

Questionnaires will soon be forwarded to every member of the State Society. It is hoped that answers will be promptly returned. . . .

Further notice of the September meeting will be given in these columns.

RENÉ BINE.

* * *

The Preparedness Parade.—This editorial comment is necessarily written before the occurrence of the much-advertised Preparedness Parade, July 22d, and, in fact, as the parade is being held, this part of the JOURNAL is on the press. However, speaking from a future view of what is going on, it seems very probable that the parade will consist

(Continued in Front Advertising Section, Page 18)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.
Secretary-Treasurer

News

"Organized medicine in California has undertaken many measures to assure adequate medical care to the people in that state. Another important step was taken last month when the California Physicians' Service, organized under the auspices of the California Medical Association in 1939, signed a contract to provide medical care to low-income farm families who have borrowed money from the Farm Security Administration (FSA). Approximately 5,000 rural families come under the initial contract, which covers three areas. If it works out in these places, it will be extended to the rest of the state, according to Laurence Hewes, regional director of the FSA. The farm families will have free choice of doctors on the panel of the California Physicians' Service. They will obtain medical care, hospitalization, and drugs. The doctors will see patients in their homes or in the doctors' offices. Cost of the service will be borne by the patients to the extent of their ability. The cost is estimated at about $50 a family a year. Of this average, the farmers will pay $35 and the Government will underwrite the remaining $15. The California contract is unique in that it offers the first agreement between the Government and the medical profession for a program of medical care to rural rehabilitation borrowers on a state-wide basis. Medical plans of country-wide scope are now in operation by the Farm Security Administration in twenty-eight states, where medical service is being furnished to almost 68,000 families. . . ." (San Francisco *Slav-American News,* May 23, 1941.)

"None save duly licensed psychiatrists may diagnose or treat mental disorders, the State Board of Medical Examiners was advised yesterday by Attorney-General Earl Warren's office. Psychiatry, Warren held, constitutes the practice of medicine and hence requires a license. A psychologist, on the other hand, may teach or study the phenomena of behavior and not violate any State laws. 'If, however,' the opinion added, 'a so-called psychologist uses the word "doctor" in his signs or advertisements, without holding a medical license, he is guilty of violating the law.' Advice of the Attorney-General was sought to define the Medical Board's powers over psychologists and psychiatrists." (San Francisco *Examiner,* May 24, 1941.)

"Creation of a State department of medical care to provide free medical, hospital, maternal and mortuary service, was proposed in an initiative constitutional amendment sent to the Attorney-General's office for titling yesterday. If the measure gets enough signatures, it will go on the ballot at the next State election. The proponent was Avery C. Moore of Oakland. The practice of medicine would be classed as a public utility. Doctors who went exclusively into State service would be classed as regulars and paid a salary, while those in private practice would be listed as associates, who would be paid when they worked for the State, but apparently would have little, if any, practice. The State's credit would be pledged for the support of the agency, with the department empowered to supplement legislative appropriations with funds it acquired." (San Francisco *Examiner,* May 23, 1941.)

(Continued in Back Advertising Section, Page 31)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

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TWENTY-FIVE YEARS AGO

(Continued from Page 22)

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From an Original Article on "Preliminary Tests of the Blood in Transfusions," by S. H. Hurwitz, M. D., San Francisco.—I wish to speak to you concerning those accidents in transfusion which may result from the incompatibility of the donor's and recipient's blood. Due to the increasing popularity of transfusion and its greater application as a therapeutic measure, it is becoming more and more necessary to exclude, wherever possible, agglutinative and hemolytic donors by careful preliminary tests. . . .

From an Original Article on "Leukopenia, Its Relation to Bronchitis," by Joseph H. Catton, M. D., San Francisco.—There have been many classifications of bronchitis on the basis of etiology. Marfan divides the infectious types into nonspecific and specific. His nonspecific bronchitides are

(Continued on Page 28)

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TWENTY-FIVE YEARS AGO

(Continued from Page 26)

usually due to streptococci or pneumococci, and they are the ones that result from the activity of organisms already in the bronchi—following a chill, inhalation of an irritant, etc., or, from an extension of an infection from neighboring parts; or, as a part of a septicemia. He calls those bronchitides specific that occur in the course of influenza, pertussis, measles, diphtheria, anthrax, plague, tuberculosis, variola, malaria, glanders and syphilis; claiming that in each case the bronchitis results from infection by a specific organism which selects the bronchial mucosa as one of its points of attack. . . .

From an Original Article on "Treatment of Diphtheria," by George E. Ebright, M. D., Assistant Professor of Clinical Medicine, University of California, San Francisco.—Interest in the subject of diphtheria has received great stimulus in the last few years in the discussion of the Schick reaction, diphtheria carriers, active immunization and of the dosage of antitoxin of diphtheria patients, and the conclusions to be drawn from personal experience are largely influenced by the mass of recent literature upon these subjects. . . .

From an Original Article on "Psychogenic Factors in Organic Disease," by C. W. Mack, M. D., Livermore.—These two cases of organic nervous disease are instructive because of the pronounced disability arising from purely neurotic conditions. The evidences of organic disease were sufficient to make a definite diagnosis, but not enough to explain the total disturbance of function. Our attention is thus called to the importance of considering the psychic

(Continued on Page 30)

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TWENTY-FIVE YEARS AGO

(Continued from Page 28)

element in organic cases, as well as those which are included among the so-called functional disorders. . . .

From an Original Article on "New San Francisco Hospital," by R. G. Brodrick, M. D., Superintendent.—The new San Francisco hospital is maintained by the city and county for the treatment of its sick poor. It is under the control of the Department of Public Health, which consists of a commission of seven members, four of whom are laymen and three are physicians.

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Excerpt from a Letter on California's Mineral Springs.—June 8, 1916.

To the Editor of the California State Journal of Medicine:

I was pleased at the contents of R. B.'s editorial in the June issue of the JOURNAL, and especially so because it shows that there is one of our profession who realizes the importance of the mineral waters of our country. Sad to tell, there are only too few of these. The profession does not scoff at the efficacy of any of the celebrated European waters, but mention a domestic mineral water and it shrugs its shoulders and smiles in derision; the physician is only aroused to a mild approval when one of his enthusiastic patients—a layman who has experienced the benefits—forces him to it.

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Today what does the medical man demand of the springs? Nothing—and he gets almost what he demands (yet the layman finds something). But the saddest part of it is he leaves undeveloped a vast resource of his state and his profession. Until the physician recognizes the various types of waters and their indications, all kinds of cases will go to all kinds of springs. Results have come from good luck on the part of the patients rather than from good management on the part of the physicians; thus have arisen the "extravagant claims and literature" which the medical profession resents, and for which it is in part responsible.

Let us hope that R. B.'s appeal for better interest on the part of the profession be heeded.

Yours sincerely,
R. H. Hunt.

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 112)

"Mrs. Clara de Brault today entered a plea of guilty to three of nine charges of performing illegal operations at 1054 Evelyn Avenue, and asked for probation in Alameda County Superior Court. . . . Representatives of the District Attorney's office moved for dismissal of the other six charges in the Alameda County Grand Jury indictment when Mrs. de Brault pleaded guilty to the three charges. . . ." (Berkeley *Gazette,* May 22, 1941.) (Previous entries, April and May, 1941.)

"Three women and one man were denied probation and given prison sentences by Judge Fred Miller today for conspiring to commit illegal operations. Another man, who played a lesser rôle in the operations of the ring, was sentenced to 180 days in jail as a condition of two years' probation. They were members of the illegal operations ring headed by Mrs. Mae Ramsey, who recently pleaded guilty to two counts and was sentenced to serve four to ten years in the women's prison at Tehachapi. Those sentenced today were on one count each, or two to five years. They include a son and a daughter of Mrs. Mae Ramsey. Claude Ramsey will go to San Quentin Prison and the daughter, Marguerite Baird Green, will join her mother at Tehachapi. The others given prison sentences to Tehachapi were Lillian Foster and Grace Balch, both of Wilmington. William Crissman of Los Angeles received the only probationary sentence. Mrs. Esther Ramsey, who pleaded guilty when the members of the ring were first arraigned, yesterday was granted full probation. She is the wife of Claude Ramsey, and probation was granted to her yesterday by Superior Judge Leslie E. Still after her counsel had informed the court that she assisted the prosecution in every way, and that she had severed all relations with the Ramsey family. . . . The sentences mark the end of one of the most successful prosecutions for illegal oper-

(Continued on Next Page)

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BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

ations on record. The prosecutions began last December with raids on one of three places operated by the ring in Torrance and Wilmington." (Long Beach *Press-Telegram,* June 9, 1941.) (Previous entries February, March, and June, 1941.)

"Alexis Nicholas Romanoff, thirty-seven, who says he is the son of the late Czar Nicholas II of Russia, was found guilty of illegally entering the United States, and today awaited action of probation officers on his application for probation. Federal Judge Ralph E. Jenney deferred sentence to June 17, pending outcome of the probation officers' investigation. Romanoff testified for more than an hour yesterday, repeating for the court what he had already told border patrol officers and immigration authorities. He said he was 'deported' from Mexico on March 20 at the point of a gun by Mexican authorities after having been kidnaped in Reno, Nevada, handcuffed, driven to Tiajuana and abandoned. After hearing counter-testimony of border patrol officers and persons who had seen Romanoff in Tiajuana, the jury declared Romanoff guilty of voluntarily leaving the United States and voluntarily reëntering the United States illegally." (San Francisco *News,* May 23, 1941.) (Previous entries, May and June, 1941.)

"Appointment of Carley V. Porter and Dr. Glenn Myers, both of Compton, as members of the board of trustees of Norwalk State Hospital was confirmed this week by the California Senate, according to word arriving here yesterday from Assemblyman Ralph Dills. Porter, member of

(Continued on Page 34)

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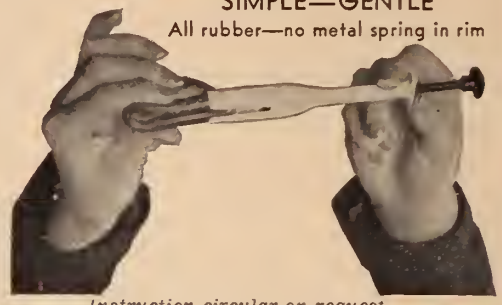

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 32)

the union secondary district board of trustees, and Doctor Myers of the Compton Sanitarium, will serve terms expiring April 8, 1945. The appointments by Governor Culbert L. Olson placed Alfred D. Boone and Dr. Arthur R. Timme on the board also." (Compton *Herald*, April 25, 1941.)

"Accused of bilking an aged Santa Cruz woman out of $600, most of her life savings, Joseph D. Menta, fifty-five, went on trial in federal court in San Francisco yesterday for impersonating a federal officer. Miss Agnes Thrift, seventy-six, member of a pioneer family in Santa Cruz, testified Menta took money from her over a long period on representation he was a herbalist who could cure her of arthritis. He gave the postoffice in Santa Cruz as his address, she said, and told her the money she gave him was 'going to the Government.' She gave him $50 on one occasion, she said, when he told her he had to pay expenses of a helper to go with him to Yosemite Park in the winter time to get a particular herb from beneath the snow. She said she financed other supposed herb-gathering trips along the California Coast. . . ." (Santa Cruz *Sentinel*, May 22, 1941.)

"Dr. Fred Rossiter, Los Angeles and Santa Fe Springs physician, who was found guilty in Whittier Township Justice Court recently of violating the State Business and

(Continued on Page 36)

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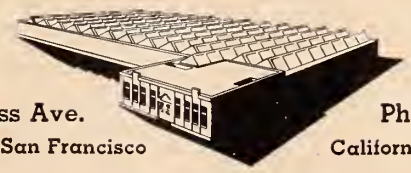

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 34)

Professional Act, had his original sentence of thirty days revoked by Judge Edward J. Guirado. Doctor Rossiter was charged with performing an illegal operation on a Long Beach woman. . . ." (Whittier *News*, May 1, 1941.) (Previous entry, April, 1941.)

"Fred N. Folsom, seventy-year-old physician, was found guilty of performing a criminal operation by a jury of seven women and five men at 2:30 o'clock this morning. The jurors had pondered over the evidence submitted them in a three and a half-day trial since 3:45 o'clock yesterday afternoon. . . . The jury foreman, Gernard Groverman, addressed the judge after the verdict had been recorded, declaring that 'it is the unanimous request of the jurors that the court extend such clemency in the case as it is possible for you to do.'" (Santa Rosa *Press-Democrat*, May 2, 1941.) (Previous entries, March and May, 1941.)

"H. F. McKay, a carpenter, is in the Tehama County Jail on a charge of practicing medicine without a license. J. W. Williams, Special Agent for the State Board of Medical Examiners, said he obtained a treatment from McKay following receipt of informal complaints that the man was posing as a doctor. His bail was set at $250. According to the investigator, McKay said he attended medical school at the University of California, University of Michigan, Queens College in Canada, and medical schools in England and Germany. When asked why he did not have a license to practice, he told the officers his diplomas were in storage in Sacramento, and for his kind of treatments he did not believe he needed a license. Williams said that McKay, under questioning, admitted that he had been practicing only about eight months and was a carpenter by trade. . . ." (Sacramento *Bee*, May 9, 1941.)

"Dr. Eugene C. Nelson, prominent local physician, who had had infrequent brushes with the authorities, is scheduled to go on trial in Superior Court May 23 to answer charges of murder, growing out of the death of an alleged

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patient upon whom he had assertedly performed an abortion. Doctor Nelson will be defended in the case to be argued before Judge Clement D. Nye, by Attorneys Hugh Culler and Lloyd Cornelius Griffith." (Los Angeles *Eagle*, May 8, 1941.) (Previous entries, April, 1940; April and May, 1941.)

"If Dr. Ralph C. Bennett, 59-year-old former Illinois State's attorney and former University of Oregon dean of men, struck Mrs. Helen Chivers and her process-server with a hammer, he did it only in self-defense, he prepared to maintain before a jury in Superior Judge A. A. Scott's court today. Doctor Bennett was expected to represent that the altercation in front of the El Monte Justice Court, where he had been in litigation with Mrs. Chivers, a Baldwin Park rest home proprietress, over a bill for the care of his aged mother, was motivated by his constant fear of violence because of a previous assault by a process-server. . . ." (Los Angeles *Herald-Express*, June 3, 1941.) (Previous entry, February, 1941.)

"Adoption of a new fee schedule for the Municipal Employees' Health Service System was hailed yesterday by Dr. Harold A. Fletcher, president of the San Francisco County Medical Society, spokesman for the 1,040 doctors who serve the System. . . ." (San Francisco *Examiner*, May 17, 1941.)

"Redlands today nods congratulations to its only centenarian, Dr. Zeeb Gilman. He plans quiet observance of

(Continued on Next Page)

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(Continued from Preceding Page)

his one hundredth birthday anniversary at his home, 836 Washington Street. Doctor Gilman is the oldest living graduate of Dartmouth College and Columbia University. . . ." (San Bernardino *Sun*, May 13, 1941.)

"Irwin A. Cole, fake Alameda doctor, who was sentenced to life imprisonment for the murder of Mrs. Betty Buckles, as result of an illegal operation, was given a future parole from Folsom prison today by the Board of Prison Terms and Paroles. 'Dr.' Cole was captured in Buffalo after the body of Mrs. Buckles, mother of two, was found in the operating room of his offices in 1927. He will be released to New York authorities in March, 1942. . . ." (San Francisco *Call-Bulletin*, May 19, 1941.)

"Mrs. Josefa Castro, east side Mexican woman who had pleaded guilty to a felony charge of performing an illegal operation, was yesterday sentenced to Tehachapi state prison for women for a term of from one to five years. Judgment was pronounced by Superior Judge O. K. Morton, who denied the woman's appication for probation. . . . Judge Morton, after reading from the report of Probation Officer C. W. Mathews that Mrs. Castro had allegedly performed several such operations upon unwed San Bernardino girls, declared he fully believed that the woman understood the seriousness of her offense at the time she performed the operations. . . ." (Riverside *Press*, May 30, 1941.)

"Not guilty" was the verdict handed down in the case of the People against Mrs. May Graham, operator of a Madera maternity home and charged with six counts of practicing midwifery without a license. The jury was out less than fifteen minutes. The sensational trial culminated two and one-half days of hearing, first begun in the local justice courtroom, then transferred to the superior courtroom because of the large crowd of interested spectators. . . . Between the clashes of the attorneys, which were very frequent, the district attorney showed the jury that Mrs. Graham was in the habit of handling birth cases in violation of the State Medical Act, which permits only licensed persons to do so, and that the element of being a good samaritan was overshadowed by the fact that she made a nominal charge in each case, taking any sum from a few dollars up to $15. . . . Thomas P. Hunter, Special Agent for the State Board of Medical Examiners, testified that Mrs. Graham, at the time Mrs. Perez entered the hospital, denied having delivered the baby and also stated that the birth certificate of the Perez baby was not filed until March 7, seventeen days after its birth. . . . Another witness, Ben Camerina, testified that Mrs. Graham, after the charges had been filed, told him to deny everything. . . . Dr. Lee A. Stone, county health officer, testified that he found the home clean, and when asked if there was any danger in having babies without the aid of skilled help, replied that babies' eyes might suffer if not properly washed by skilled persons. . . ." (Madera *News*, May 29, 1941.) (Previous entries, April and June, 1941.)

"Dr. Levin Osel of Monterey has been named by the Board of Supervisors to take charge of the Plumas County Hospital to succeed Dr. F. H. Bowles, effective July 1. . . ." (Sacramento *Bee*, June 6, 1941.)

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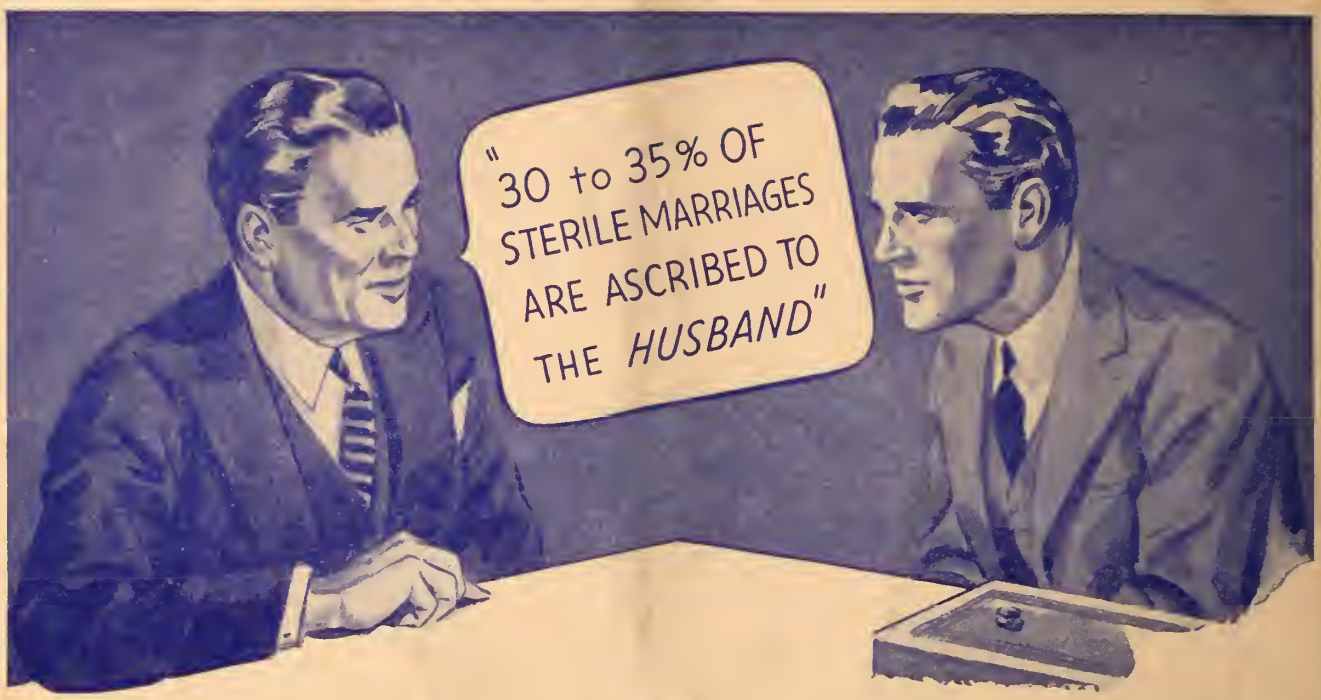

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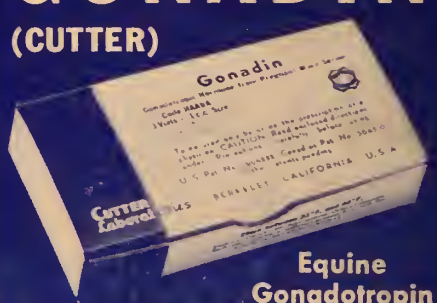

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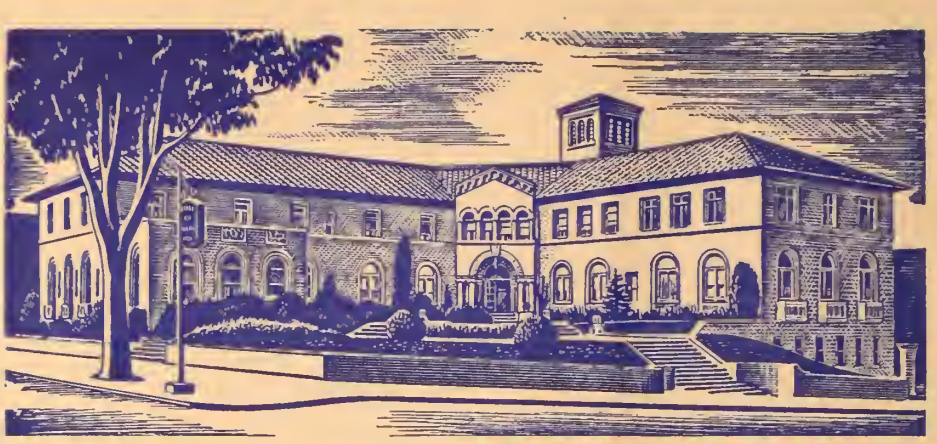

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(Continued on Page 5)

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(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association
2404 Broadway, Oakland

President, John W. Sherrick, 350 Twenty-ninth Street, Oakland.
Secretary, Gertrude Moore, 353 30th Street, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn County Medical Society

President, Charles Benninger, Jr., Oroville.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society

President, R. J. P. Harmon, 314 Tenth Street, Richmond.
Secretary, L. Abbott Hedges, 912 Macdonald Avenue, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society

President, Frank R. Ruff, 1234 S Street, Fresno.
Secretary, J. E. Young, 405 Rowell Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society

President, Lowell G. Kramar, 1049 Main Street, Fortuna.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society

President, William A. Clarke, 132 Fifth Street, Holtville.
Secretary, Claude F. Peters, 722 Main Street, El Centro.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society

President, H. W. Crook, 106 S. Main, Bishop.
Secretary, George Shultz, 124 N. Main, Lone Pine.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society

President, Lucille B. May, 1706 Chester Ave., Bakersfield.
Secretary, Sophie M. Loven, 458 Haberfelde Building, Bakersfield.
Meeting, *Third Thursday, 8:00 p. m.*

Kings County Medical Society

President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, Arthur Zeismer, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society

President, W. B. McKnight, Portola.
Secretary, Bernard S. Holm, Quincy.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles

President, Thomas C. Myers, 1501 So. Figueroa Street, Los Angeles.
Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society

President, Wilson P. Goddard, 308 Throckmorton Street. Mill Valley.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, Deer Park Villa, Fairfax.*

Mendocino-Lake County Medical Society

President, Royal Scudder, 123 Laurel Street, Fort Bragg.
Secretary, Otto L. Gericke, Mendocino State Hospital, Talmage.
Meeting, *on Call.*

Merced County Medical Society

President, A. B. Bigler, 165 N. Second Street, Chowchilla.
Secretary, James A. Parker, Bank of America Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society

President, James McPharlin, 8 East Alisal Street, Salinas.
Secretary, R. D. Mace, 601 South Main Street, Salinas.
Meeting, *First Thursday.*

Napa County Medical Society

President, R. C. Burkett, 1130 First Street, Napa.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association

President, Lawrence C. Cameron, 218 South Main Street, Santa Ana.
Secretary, Milo K. Tedstrom, 1626 Bush Street, Santa Ana.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society

President, Lucas W. Empey, Roseville.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society

President, Wayne K. Templeton, 3770 Twelfth Street, Riverside.
Secretary, Hobart M. Kelly, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement

President, Frank Warne Lee, 510 Physicians Building, Sacramento.
Secretary, Curtis H. McDonnell, California State Life Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society

President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society

President, Eugene H. Hull, San Bernardino.
Secretary, A. E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
1410 Medico-Dental Building, 233 A Street, San Diego

President, Frank A. St. Sure, 4067 Van Dyke Avenue, San Diego.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
2180 Washington Street. San Francisco

President, Harold A. Fletcher, 490 Post Street, San Francisco.
Secretary, L. Henry Garland, 2180 Washington Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society

President, Raymond Leroy Owens, 28 Cory Building, Lodi.
Secretary, George H. Rohrbacher, 1005 Medico-Dental Building, Stockton.
Acting Secretary, C. A. Broaddus, 242 North Sutter Street, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society

President, Horace Hagan, 1215 Chorro Street, San Luis Obispo.
Secretary, E. M. Bingham, County Health Department, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Drayon Cafe, San Luis Obispo.*

San Mateo County Medical Society

President, H. H. Whitney, 1204 Burlingame Avenue, Burlingame.
Secretary, Thomas Farthing, 23 Second Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society

President, H. R. Schwalenberg, Cottage Hospital, Santa Barbara.
Secretary, D. H. McNamara, 317 W. Pueblo Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society

President, A. J. Baiocchi, 369 South Third Street, San Jose.
Secretary, Leon P. Fox, Ste. Claire Building, San Jose.
Meeting, *Third Monday, 7:00 p. m., Sainte Claire Hotel, San Jose.*

Santa Cruz County Medical Society

President, Avery Wood, 335 Main Street, Watsonville.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meeting, *First Tuesday of each month (except June, July and August), 7:30 p. m., Club Rio del Mar, Aptos.*

Shasta County Medical Society

President, Earnest Dozier, Redding.
Secretary, Julius M. Kehoe, Redding.
Meeting, *Second Monday.*

Siskiyou County Medical Society

President, F. W. Martin, 106 Orem Street, Mt. Shasta.
Secretary, Victor W. Hart, 113 No. Oregon Street, Yreka.
Meeting, *Sunday on call.*

Solano County Medical Society

President, Gordon Bunney, Suisun.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Tuesday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society

President, Leighton Ray, 536 B Street, Santa Rosa.
Secretary, J. F. Thurlow, 576 B Street, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society

President, Hoyt R. Gant, 1024 J Street, Modesto.
Secretary, A. E. Ghilotti, 1024 J Street, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society

President, R. G. Frey, Red Bluff.
Secretary, F. J. Bailey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society

President, Ray E. Cronemiller, 160 South E Street, Exeter.
Secretary, Forrest G. Powell, 222 W. Willow Street. Visalia.
Meeting, *Sunday Evening once a month.*

Ventura County Medical Society

President, James W. Moore, 23 S. California Street, Ventura.
Secretary, Robert K. Harker, 132 Fourth Street, Oxnard.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society

President, Edwin K. Copeland, 405 First Street, Woodland.
Secretary, Wilfred T. Robbins, 719 Second Street, Davis.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society

President, Romayne B. Whitney, Plumas Street, Yuba City.
Secretary, Leon M. Swift, I. O. O. F. Building, Marysville.
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In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco.

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Southern California Medical Association

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The Public Health League of California

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1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," Am. J. Syph., Gon. & Ven. Dis., 23, 201 (March), 1939.

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Lymphatics, Lymph, and Lymphoid Tissue. Their Physiological and Clinical Significance. By Cecil Kent Drinker, M. D., D. Sc., Professor of Physiology, School of Public Health, Harvard University, and Joseph Mendel Yoffey, M. Sc., M. D., F. R. C. S. (Eng.), Senior Lecturer in Anatomy, University College of South Wales and Monmouthshire, Cardiff, Wales. First Edition. Cloth. Price, $4. Pp. 406, with 49 illustrations. London: Humphrey Milford, Oxford University Press. Cambridge, Massachusetts: Harvard University Press, 1941.

The Care of the Aged. (Geriatrics.) By Malford W. Thewlis, M. D., Attending Specialist, General Medicine, United States Public Health Hospitals, New York City; Attending Physician, South County Hospital, Wakefield, R. I.; Special Consultant, Rhode Island Department of Public Health. Third Edition, Entirely Rewritten. Cloth. Pp. 579, with 50 illustrations. St. Louis: The C. V. Mosby Company, 1941.

Clinical and Experimental Investigations of the Genital Functions and Their Hormonal Regulation. By Bernhard Zondek. First Edition. Cloth. Price, $4.50. Pp. 264, with illustrations. Baltimore: The Williams & Wilkins Company, 1941.

Essays on the Applied Physiology of the Nose. By Arthur W. Proetz, A. B., M. D., Professor of Clinical Otolaryngology in the Washington University School of Medicine. Fellow of the American Laryngological Association, the American Otological Society, the American Laryngological, Rhinological and Otological Society, the American Academy

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BOOKS RECEIVED

(Continued from Preceding Page)

of Ophthalmology and Otolaryngology, American Medical Association, Biological Photographic Association, etc. First Edition. Cloth. Pp. 395, with 91 illustrations. St. Louis, Missouri: Annals Publishing Company, 1941.

Essentials of Electrocardiography. For the Student and Practitioner of Medicine. By Richard Ashman, Ph. D., Professor of Physiology, the Louisiana State University Medical Center; Director of the Heart Station, Charity Hospital of Louisiana, New Orleans, and Edgar Hull, M. D., Professor of Medicine, Louisiana State University Medical School; Senior Visiting Physician, Charity Hospital of Louisiana, New Orleans. Second Edition. Cloth. Price, $5. Pp. 373, with 122 illustrations. New York: The MacMillan Company, 1941.

The Complete Weight Reducer. A New Kind of Book. Virtually Eight Books in One. Reducing Diets and Menus. The Modern Spot Reducer. Handbook of Diet Systems. Obesity Charts and Tables. Manual of Slimming Garments. Reducer's Guide to Food Products. American Directory for the Overweight. Quackeries and Frauds in Weight Reduction. By C. J. Gerling, Author of "Short Stature and Height Increase." First Edition. Price, $3. Pp. 246. New York: Harvest House, 1941.

The Therapeutics of Internal Diseases. Volume IV. Supervising Editor, George Blumer, M. A. (Yale), M. D., David P. Smith, Clinical Professor of Medicine, Yale University School of Medicine; Consulting Physician to the New Haven Hospital. Associate Editor, Albert J. Sullivan, M. D., Adjunct Clinical Professor of Medicine, George Washington and Georgetown Medical Schools; Chief Medical Officer, Gallinger Municipal Hospital, Washington, D. C. Contributors: George Blumer, Yale University School of Medicine; Joseph S. Barr, Harvard Medical School; Philip W. Brown, The Mayo Foundation; Russell S. Ferguson,

(Continued on Page 10)

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Associate Surgeon, New York Hospital; Robert S. Hotchkiss, Cornell University Medical College; Richard Hotz, Lucas County Hospital, Toledo, Ohio; Raphael Isaacs, Michael Reese Hospital; Chevalier L. Jackson, Temple University School of Medicine; Herman O. Mosenthal, New York Postgraduate Medical School; Luther K. Musselman, Yale University School of Medicine; Charles L. Short, Harvard Medical School; Albert J. Sullivan, George Washington and Georgetown Medical Schools; John Russell Twiss, New York Postgraduate Medical School; and Frank C. Yeomans, Cornell University School of Medicine. Cloth. First Edition. Sold only as a set. Five volumes. Price, $50. Pp. 791, with illustrations. New York and London: D. Appleton-Century Company, 1941.

A Textbook of Bacteriology. By R. W. Fairbrother, D. Sc., M. D., M. R. C. P., Director of the Clinical Laboratory, Manchester Royal Infirmary; Special Lecturer in Bacteriology, University of Manchester; Major, R. A. M. C.; Late Research Fellow in Bacteriology, Lister Institute, London. Third Edition. Cloth. Pp. 451, with illustrations. St. Louis: The C. V. Mosby Company, 1941.

The Therapeutics of Internal Diseases. Volume V. Supervising Editor, George Blumer, M. A. (Yale), M. D., David P. Smith, Clinical Professor of Medicine, Yale University School of Medicine, Consulting Physician to the New Haven Hospital; Associate Editor, Albert J. Sullivan, M. D., Adjunct Clinical Professor of Medicine, George Washington and Georgetown Medical Schools; Chief Medical Officer, Gallinger Municipal Hospital, Washington, D. C. Contributors: Warren T. Brown, Yale University School of Medicine; Walter S. Burrage, Harvard Medical School; Louis S. Goodman, Yale University School of Medicine, Alexander Marble, Harvard Medical School; Vera G. Mather, Yale University School of Medicine; H. H. Merritt, Harvard Medical School; Elbert L. Persons, Duke Uni-

(Continued on Page 14)

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versity School of Medicine; David T. Smith, Duke University School of Medicine; Susan Gower Smith, Duke University School of Medicine; and Henry H. Turner, University of Oklahoma School of Medicine. First Edition. Cloth. Sold only as a set. Five volumes. Price, $50. Pp. 765, with illustrations. New York and London: D. Appleton-Century Company, 1941.

Pathology of the Oral Cavity. By Lester Richard Cahn, D. D. S., Associate Professor of Dentistry (Oral Pathology) Columbia University, Fellow of the American Association for the Advancement of Science, Fellow of the New York Academy of Dentistry, Associate Fellow of the New York Academy of Medicine. First Edition. Cloth. Price, $5.50. Pp. 240, with 165 illustrations. Baltimore: The Williams & Wilkins Company, 1941.

Essentials of Pharmacology and Materia Medica for Nurses. By Albert J. Gilbert, M. D., Instructor of Pharmacology, Aultman School of Nursing, Canton, Ohio; Formerly Instructor of Pharmacology and Therapeutics, John Sealy College of Nursing; Formerly Instructor of Pharmacology, University of Texas Medical School, Galveston, and Selma Moody, R. N., Instructor in Nursing Arts, the Presbyterian Hospital of the City of Chicago. Cloth. First Edition. Pp. 251, with 11 illustrations, and 4 color plates. St. Louis: The C. V. Mosby Company, 1941.

Principles of Microbiology. By Francis E. Colien, B. S., M. S., Ph. D., F. A. P. H. A., Associate Professor of Bacteriology and Preventive Medicine in the Creighton University School of Medicine; Lecturer in Public Health and Preventive Medicine, Creighton Memorial, St. Joseph's Hospital School of Nursing, Omaha; Director of Laboratories, Health Department, City of Omaha; Major, Sanitary Division, United States Army Medical Reserve; Formerly Professor of Bacteriology and Preventive Medicine

(Continued on Page 16)

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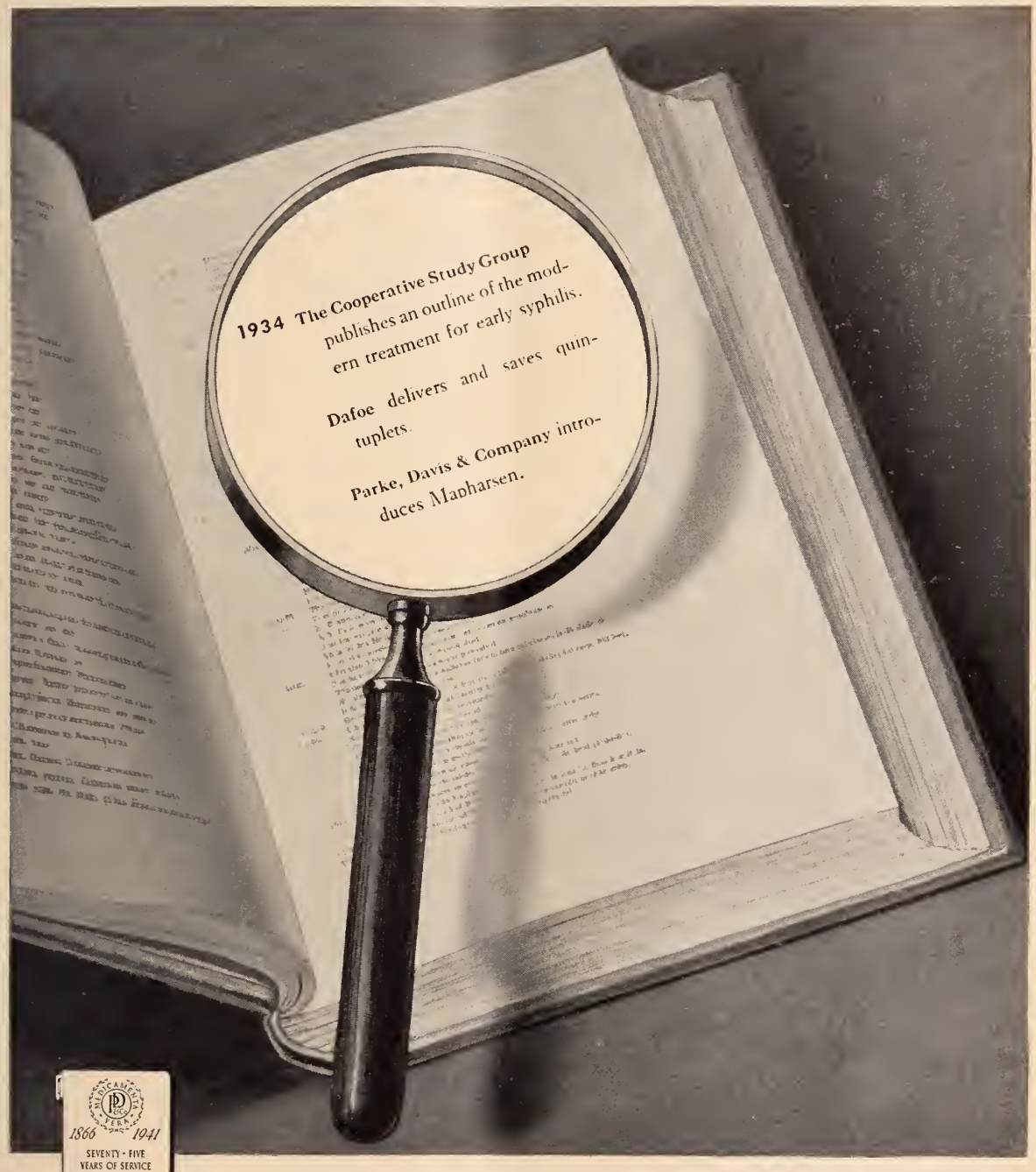

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in the Central School of Nursing, Milwaukee, and Ethel J. Odegard, R. N., A. B., M. A., Instructor in Sciences Applied to Nursing, College of Saint Teresa, Winona, Minnesota; Formerly Director of Nursing Education in the Central School of Nursing, Milwaukee; Education Director, Miami Valley Hospital School of Nursing, Dayton, Ohio. First Edition. Cloth. Price, $3. Pp. 444, with 140 text illustrations, and 18 color plates. St. Louis: The C. V. Mosby Company, 1941.

Body Mechanics in Health and Disease. By Joel E. Goldthwait, M. D., F. A. C. S., LL. D., Member of Board of Consultants, Massachusetts General Hospital; Ex-President of American Orthopedic Association; Organizer and First Chief of Orthopedic Service, Massachusetts General Hospital; Member of American Academy of Orthopedic Surgery; Member of British Orthopedic Association; and Lloyd T. Brown, M. D., F. A. C. S., President of the Robert B. Brigham Hospital, Member of American Orthopedic Association; Member of American Academy of Orthopedic Surgery; Member of Board of Orthopedic Surgery; Instructor in Orthopedics, Harvard Medical School; and Loring T. Swaim, M. D., Secretary of American Rheumatism Association; Member of American Orthopedic Association; Member of American Academy of Orthopedic Surgery; Instructor, Orthopedic Surgery, Harvard Medical School; Chief Orthopedic Consultant, Robert B. Brigham Hospital; and John G. Kuhns, M. D., F. A. C. S., Member of American Orthopedic Association; Member of Academy of Orthopedic Surgery; Assistant in Orthopedic Surgery, Harvard Medical School; Chief of Orthopedic Staff, Robert B. Brigham Hospital. With a Chapter on the Heart and Circulation as Related to Body Mechanics, by William J. Kerr, M. D., F. A. C. P., Professor of Medicine, University of California Medical School; Physician in Chief, University of California Hospital; Member of American Board of Internal Medicine; Formerly President, American Heart Association, American Rheumatism Association, and American College of Physicians. Third Edition. Completely Revised and reset. Cloth. Pp. 316, with 121 illustrations.

(Continued on Page 18

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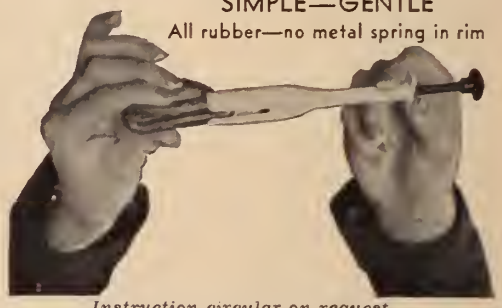

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Philadelphia, London, and Montreal: J. B. Lippincott Company, 1941.

New and Nonofficial Remedies, 1941. Containing Descriptions of the Articles which Stand Accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1941. First Edition. Cloth. Pp. 691. Chicago: American Medical Association, 1941.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1941 with the comments that have appeared in the Journal. Cloth. Pp. 177. Chicago: American Medical Association, 1941.

Necropsy. A Guide for Students of Anatomic Pathology. By Bela Halpert, M. D., Assistant Professor of Pathology

(Continued on Page 20)

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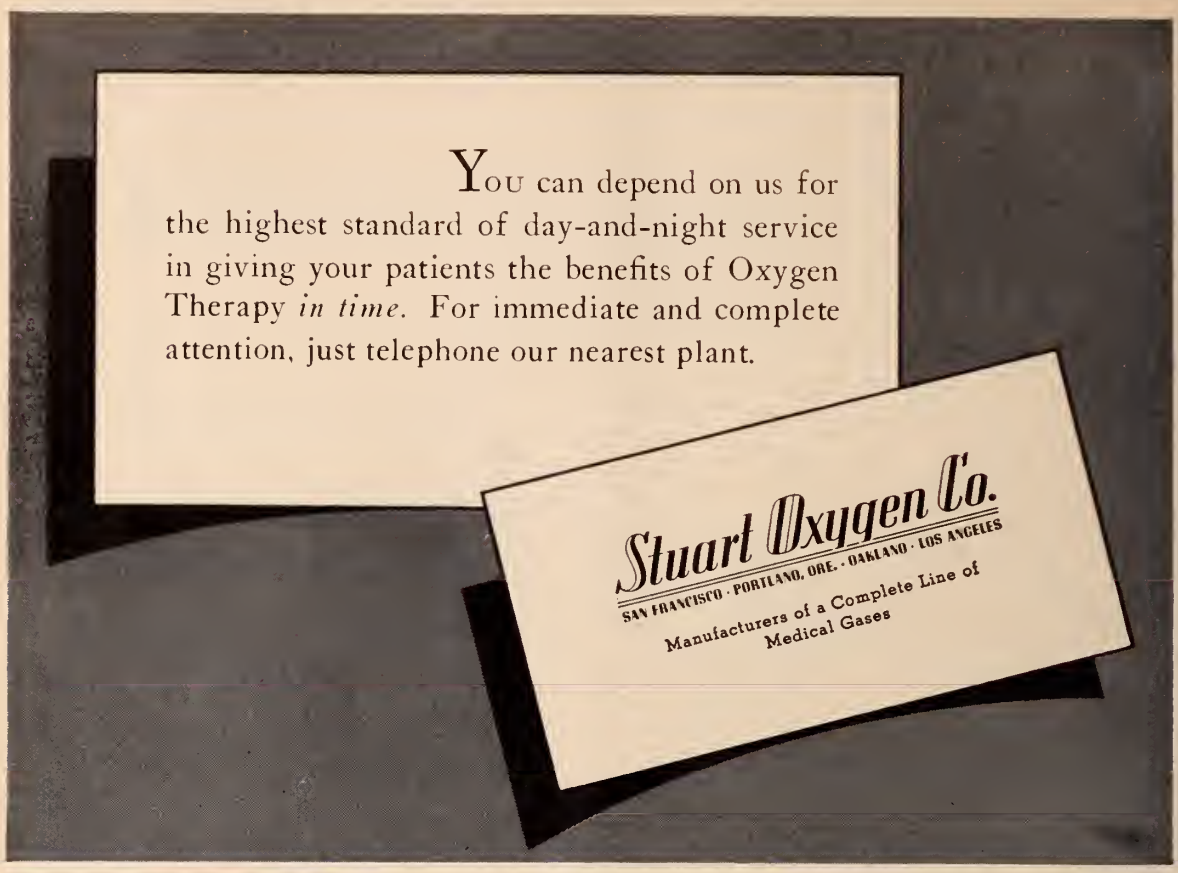

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and Bacteriology, Louisiana State University School of Medicine, and Visiting Pathologist, Charity Hospital of Louisiana at New Orleans. First Edition. Cloth. Pp. 75. St. Louis: The C. V. Mosby Company, 1941.

BOOK REVIEWS

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1940. C'oth. Price, $1. Pp. 181. Chicago: American Medical Association, 1941.

This volume contains not only all of the published reports of the Council for the preceding year, but also reports on products which were not deemed important enough to be published in *The Journal*. Council reports may be classified in general as those of omission or rejection, preliminary reports and status reports on drugs or on various therapeutic and pharmacologic problems. Representatives of all classes appear in this volume.

There are a number of interesting reports in the "non-acceptable" category. The one on the widely exploited Neurosine of the Dios Company sounds a timely warning on the hazards of bromidism and uncontrolled hypnotic medication. The report rejecting a number of preparations of gonadotropic hormone from the serum of pregnant mares, together with the report rejecting certain ovarian and ovarian anterior pituitary preparations, attest the Council's continued critical interest in the field of endocrinology. This is also indicated in the report on Desoxycorticosterone, written by Dr. Edgar S. Gordon and adopted by the Council for publication with a statement of the Council's attitude on the present status of adrenal cortex. The Council finds adrenal cortex therapy now in an unsatisfactory and unsettled state.

Two reports relegate to the therapeutic scrap heap the drugs Isacen and Melubrin: Isacen was accepted in 1926 as a nontoxic laxative or purgative; Melubrin is an antipyretic which seemed to have promise when it was accepted in 1913, but which the manufacturer has now ceased

(Continued on Page 22)

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BOOK REVIEWS

(Continued from Page 20)

marketing. It is interesting to note that at the time these preparations were accepted the Council expressed some misgiving which later proved justified.

Noteworthy preliminary reports are on Guanidine Hydrochloride-Calco, which has been proposed for use in the treatment of myasthenia gravis, and Acetylglycarsenobenzene, a new antisyphilitic for intramuscular use, which the Council feels should be further perfected. In its report the Council comments with approval upon the manner in which the Winthrop Chemical Company has developed the latter and studied it before even considering its commercial production.

Among the nomenclature reports are those designating "Pyridoxine" and "Pyridoxine Hydrochloride" for Vitamin B_6 and Vitamin B_6 Hydrochloride; "Sulfathiazole" for 2-Sulfanilamidothiazole and "Sulfamethylthiazole" for 2-Sulfanilamido-4-Methylthiazole. Preliminary reports on these drugs as well as on Phenothiazine and Histaminase are included.

It is difficult to choose any among the so-called status reports for special mention—all are noteworthy for one reason or another. The report on the present status of the injection treatment of hernia is a continuation of the Council's consideration of this question. The Council has reached the decision that it is necessary to condemn the exploitation of the injection treatment of hernia by manufacturers of solutions.

Another status report that must be mentioned is that on Lipocaic, a new pancreatic hormone concerned in some some way with the normal transport and utilization of fat. The Council awaits development of further clinical evidence for Lipocaic and expressed the opinion that the method should not be recognized for routine practice.

Mention must be made of the excellent report on organic mercurial compounds as bactericidal agents, which states the Council's conclusion that no organic mercurial compound has yet been offered that will guarantee the destruction of spores under all conditions.

Another valuable report is that on the promiscuous use of the barbiturates. This is a continuation of a previous

(Continued on Page 24)

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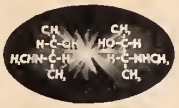

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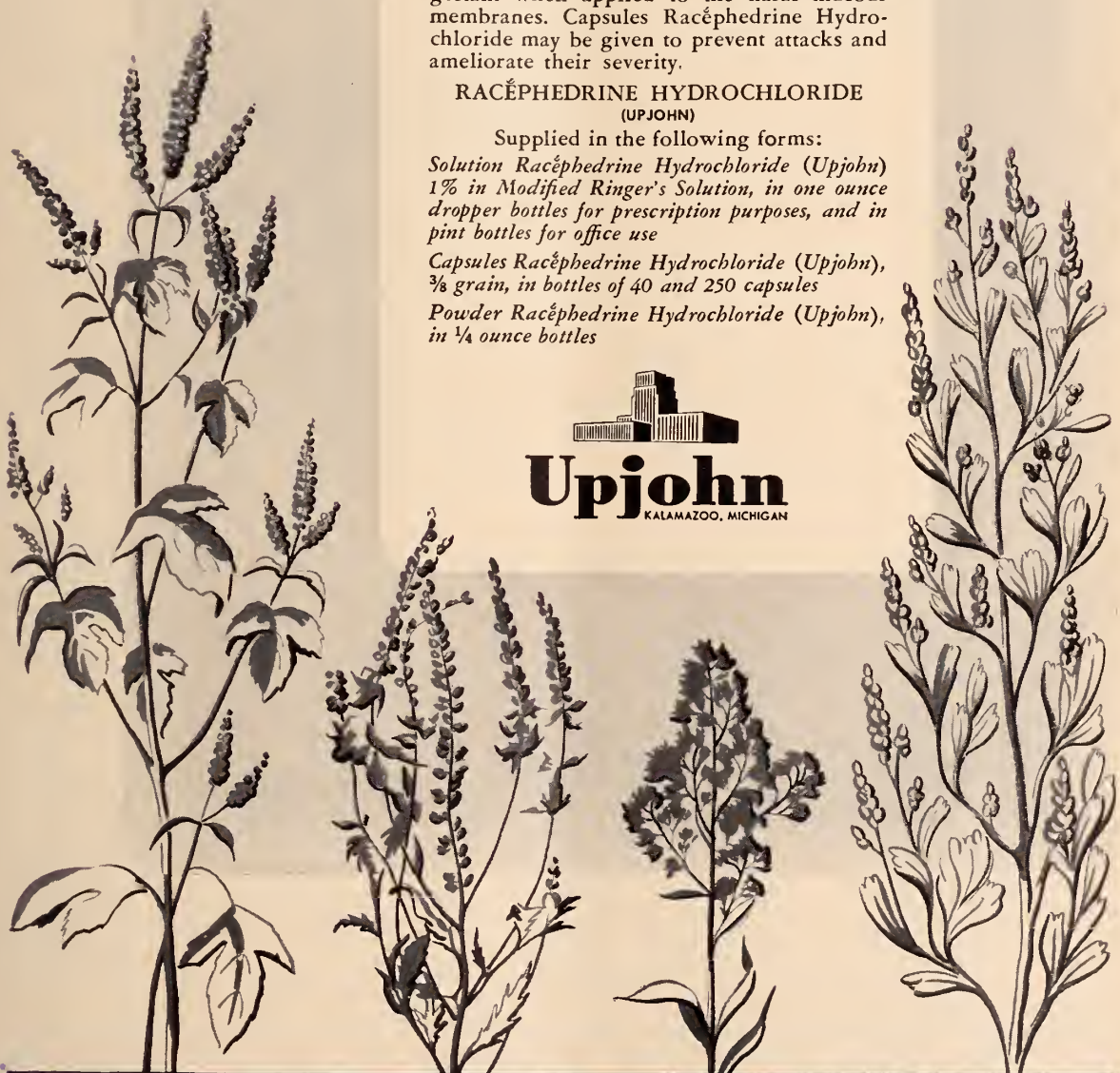

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BOOK REVIEWS

(Continued from Page 22)

study of the use of barbiturates in suicide. The present study is an analysis of hospital data.

One cannot even glance through a volume such as this without reflection on the great value of the Council on Pharmacy and Chemistry's work, which so richly deserves the support of all who are interested either directly or indirectly in the progress of medicine.

New and Nonofficial Remedies, 1941, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1941. Cloth. Price, postpaid, $1.50. Pp. 691—LXX. Chicago: American Medical Association, 1941.

New and Nonofficial Remedies is the book in which are described the medicinal preparations found by the Council on Pharmacy and Chemistry to be acceptable for the use of physicians. The book is cumulative; each year there are added the descriptions of products accepted during the foregoing year. Those taken off the market or found no longer worthy of continued acceptance are deleted. The book is at that time also revised to bring it up to date with the most recent medical thought. Until recent years the additions and deletions have about balanced. Recently, however, the bulk of the book has been increasing, and this year's volume represents the largest book of the more than thirty volumes that have been issued.

This year's new additions include the new sulfanilamide derivative, sulfathiazole, as well as sulfapyridine sodium; antipneumococcic rabbit serum of Types I, II, III, V, VII, and VIII; human convalescent measles serum and human convalescent scarlet fever serum; and staphylococcus antitoxin. The field of endocrinology is represented by the addition of chorionic gonadotropin (follutein). The addition of shark liver oil reflects the search for new sources of vitamins A and D, caused by the cutting off of foreign cod-liver oil. Other newly accepted preparations are ampoules of camphor, digilanid, and magnesium trisilicate.

The most extensive revision is represented by the rearrangement and amplification of the chapter, Serums and

(Continued on Page 26)

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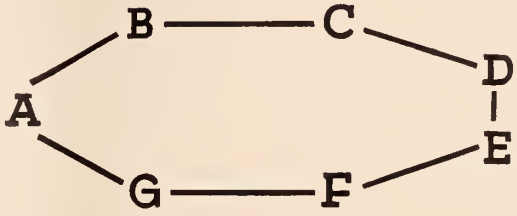

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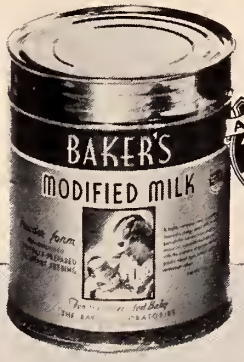

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BOOK REVIEWS

(Continued from Page 24)

Vaccines. This chapter is now prefaced by a helpful index, an innovation in New and Non-official Remedies. The chapter, Vitamins and Vitamin Preparations for Therapeutic and Prophylactic Use has been revised to keep it abreast of the newer developments in this field. Here, too, we find something of an innovation in the systematic use of graphic chemical formulas. It is understood that this practice will be extended to other parts of the book in future editions. Careful perusal will reveal minor revisions in many parts of the book made in the interest of greater clarity and in the effort to keep the book thoroughly up to date.

Magic in a Bottle. Being the true narratives of ten wonder-working drugs and of the doughty men who, wittingly or unwittingly, discovered them. By Milton Silverman, Ph. D. Cloth. Price, $2.50. Pp. 332. New York: The Macmillan Company, 1941.

A very interesting history of medicine covering the last three centuries, beginning with the first study endeavors of the early apothecaries, and revealing, for that period, the silent individual students in their little back rooms, and today the highly equipped laboratories.

The author has brought much medical history into his single volume, filling it with informative data, all carefully tabulated. Members of medical and pharmaceutical professions, and laymen also, will find much of interest in this book.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 166)

cannot be met fully by existing agencies and can only be properly remedied by a system of compulsory health insurance embracing all wage-earners and dividing the cost among employer, employee, and the state. . . .

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(Continued in Back Advertising Section, Page 30)

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OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

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Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number see index below.)

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must he received not later than the fifteenth of the month preceding issue. Advertising rates will he sent on request.

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Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contrihuted solely to this Journal. New copy must he sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed hy the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

CALIFORNIA'S FIFTY-FOURTH LEGISLATURE: IN RETROSPECT

Large Number of Proposed Laws.—On Saturday, June 14, this year's Legislature—California's fifty-fourth—adjourned, with a record of more than four thousand measures having been submitted. In line with past experience, it was found that several hundred proposed laws had public health and medical practice implications; almost one hundred of this latter group containing provisions that could play havoc, if passed, with desired objectives.

Members of the medical profession should feel pleased in the knowledge that no legislation of vicious nature went on to enactment, and subsequent placement in the statute books of the State.

Comment will be made, first, on certain measures in which the California Medical Association had special interest, and, secondly, on proposals submitted from various other sources, the purposes of which would not make for a betterment of existing or future conditions in medical practice.

* * *

Some Measures of Special Interest.—At the California Medical Association session held in 1940, at Coronado, *Resolution No. 23* on "Pound Legislation" (CALIFORNIA AND WESTERN MEDICINE, June, 1940, pages 271 and 294), recommended the passage of a law that would permit "the use of unclaimed animals from the public pounds by recognized scientific organizations for investigative purposes." In the recent legislature, a measure, known as Senate Bill 488, drafted to accomplish this aim, met with serious opposition from the antivivisectionist group, became also the source of considerable newspaper comment, and after strenuous discussion in committee hearings, was tabled in executive session by the Senate Committee on Public Health.

At the Coronado meeting, Doctor Bullock of Los Angeles introduced *Resolution No. 24 for proposed legislation granting traffic law exemptions to physicians* when responding to emergency calls, the same being adopted (CALIFORNIA AND WESTERN MEDICINE, June, 1940, pages 271 and 294). An act drafted and introduced as Assembly Bill 690 went on to enactment, now being recorded as Chapter 573, Section 454.2 of the Vehicle Code

† Editorials on subjects of scientific and editorial interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

of California. Reference to this measure is made under Item 20 of the minutes of the California Medical Association Council, appearing in this issue on page 144.

The text of the new law which, with other statutes, will become operative ninety days after the June 14 adjournment, namely, on September 3, reads as follows:

The people of the State of California do enact as follows:

Section 1. Section 454.2 is hereby added to the Vehicle Code, to read as follows:

454.2. Vehicles Owned by Physicians. A physician traveling in response to an emergency call shall be exempt from the provisions of Section 511 of this code; provided, the vehicle so used by him displays an insignia approved by the Department of Motor Vehicles, indicating that such vehicle is owned by a licensed physician. The provisions of this section shall not relieve the driver of any such vehicle from the duty to drive with due regard for the safety of all persons using the highway, nor shall the provisions of this section protect any such driver from the consequences of an arbitrary exercise of the privileges declared in this section.

It is to be regretted that the statute did not provide that the special insignia, to be placed on automobiles, should be secured from the California Department of Motor Vehicles, through applications previously approved by the state examining boards of physicians. However, the beginning has been made.

Assembly Bill 1625, a measure designed particularly to make it possible for *nonprofit medical service organizations to contract with public agencies* for health services needed in the care of persons on relief, did not receive the approval of the Assembly Committee on Ways and Means. The issues involved are important. Thanks are due, however, to the committee whose members gave much thought to the measure. The subject is worthy of continued study, with possible and hoped-for future action and adoption.

As the result of Assembly Bill 563, a law will find a place on the statute books that will render important service in establishing *California Physicians' Service, a nonprofit corporation, on a firmer foundation.*

Assembly Bill 1475, the so-called "foreign doctors' bill," became a law in spite of veto by Governor Olson, the gubernatorial rejection being overridden after a bitter contest.

In the Legislature of 1939, the *compulsory health act* was one of Governor Olson's "must pass" measures, but in spite of such blessing, after a bitter fight, it went down to defeat, the story being told at the time in California and Western Medicine. Similar bills were introduced in the 1941 legislative session (A. B. 1730 and S. B. 645), but never were pushed, even for first steps in committee hearings. These measures will, of course, again come to the front two years hence.

It is to be regretted that efforts to make possible the *compensation of physicians and surgeons upon whom the care of persons injured in accidents may have fallen*, when such injured persons become the beneficiaries of sums collected because of such injuries, did not receive approval by legislators. Such "lien bills" are virtually in vogue in many court procedures. Here, also, the battle for fair dealing will probably continue.

Elsewhere, on page 147 of this issue of California and Western Medicine is given a summary of the past year's legislation relating to medical practice, and members should find its inspection of interest and value.

* * *

Expressions of Appreciation Are in Order.—These comments should not close without calling attention to two things:

1. The splendid work rendered by the California Medical Association and County Committees on Public Policy and Legislation, to whom, and to all who thus aided, thanks of the Association are tendered.

2. And the kindly spirit in which Senators and Assemblymen conferred with representatives of the medical profession on matters of public health. To these legislators, also, thanks are given for their sympathetic coöperation and aid.

In this connection, component county societies and members of the California Medical Association should not forget to maintain all cordial contacts already established. Why not, for example, as many societies do, invite your legislators as guests at one of the get-together meetings? In this number of the Official Journal appears an item concerning the recent four-county meeting at Vallejo. Its perusal will reveal how one group of physicians in the East Bay section of the San Francisco area maintain cordial relationships with lawmakers, such as are always agreeable and helpful. The example is worthy of emulation.

PHYSICAL REHABILITATION OF SELECTEES: BY WHAT METHOD?

Experiences of Local Draft Board Examiners. Physicians who have been giving their services without cost to the Government, as examiners for local draft boards, early in their work recognized that a variety of physical defects, many sufficient to entitle the selectee under consideration to a nonmilitary classification, were of a remedial, surgical or other nature.

However, nothing could be done in the premises, since there was nothing in the Selective Draft Act whereby rehabilitation services could be provided by the Government, to be accepted by the selectee, voluntarily or otherwise.

Recently, press dispatches from Washington have brought the information that the Federal Security Administration, through a special committee, has espoused a plan bearing on this problem, as witness:

The national selective service director would issue instructions to local board chairmen on placing registrants with remediable defects, and limited means, under the care of hospitals and other agencies designated for the purpose by local rehabilitation committees. Local boards would set a limit for correction of any defect and require the registrant to present himself for reclassification.

* * *

Recommendations of Federal Security Administration.—The changes recommended by the

Commission and approved by Federal Security Administrator Paul V. McNutt, follow:

1. Creation of two new subclassifications for registrants, namely, 1 B-R and IV F-R, the R signifying the registrant is suffering from a defect that is *"remediable or correctible."*

2. Report of physical examinations to include a place for the examining physician to state whether the physical defect causing rejection is remediable.

3. Statement to be signed by the registrant relative to (*a*) his willingness to undergo treatment; (*b*) permission for release of information on his physical condition which now is kept secret; (*c*) whether he can pay for his own treatment.

4. Amendment of regulations *"to permit the examination at any time of confidential records pertaining to the physical condition of a registrant by the governors of states or designated officials."*

5. Reports in duplicate to be made of physical condition, with one copy going to the "state rehabilitation boards."

6. A change in regulations so that chairmen of local boards can *"advise the registrant of the time that the board has allowed for the correction of his defect, at the expiration of which time the registrant must present himself to the board for reëxamination."*

* * *

Further Study and Recommendation May Follow.—The subject above referred to may be only the beginning of a study or survey to determine whether the existing system of examination of selectees is one that will work out best in the interests of the selectees, the Government, the medical examiners and local draft boards, and others who bear responsibilities in this important work.

Certainly, the ultimate cost to the Government and taxpayers will be heavy indeed, if the medical records fail to measure up to best standards. If the nation is to maintain a large standing army and navy—and present signs so indicate—will it be wise to expect the professional services of physician examiners to be given year after year without compensation? Physicians in California who have borne heavy burdens in the examination of selectees and who are willing to continue to give such gratuitous service, have expressed themselves as favoring a plan whereby a lesser number of medical examiners, on pay, would assume the major portion of the work. It is the contention that the examinations would result in better records for the Government, with great ultimate saving and satisfaction to all concerned. There are many phases to this problem, and because of the large number of physicians taking part in the work, and the responsibilities involved, sober discussion on the best methods of procedure is almost certain to continue. The recent interesting announcement by the Federal Security Administration but emphasizes this fact.

COUNTY SOCIETY ACTIVITIES: FALL WORK

Preparation of Meeting Programs.—With this issue of California and Western Medicine, many component county societies will resume meetings. The thought is expressed that the vacation period now closing will have fulfilled its reason for being, in that members everywhere will come back to their work with increased zest and a desire to promote the best interests of scientific and organized medicine.

Because most county units, in December, elect their officers for the next calendar year, there is often a program break in January, when new officers and committees begin to function. It would seem, therefore, a wise procedure for a county society to have its officers outline in advance the nature of the meetings to be held, not only for the remaining months of the present year, but also, say, for the spring months of the next year.

What are some of the major matters to be considered by county society officers and program committees? Among such, concerning which mention may be made in local bulletins or at meetings, may be mentioned items such as are noted below.

* * *

Concerning Scientific Medicine.—Shall each meeting's program be left to chance, or shall a progressive series of interrelated topics be outlined? Who shall be the local speakers or essayists? Who, the guest speakers?

Regarding a Clinical Conference or Refresher Course:

Has your local Committee on Postgraduate Work written to the California Medical Association Committee on Postgraduate Activities, in care of the Association Secretary, 450 Sutter, San Francisco, regarding a clinical conference?

What would be the topics of most interest and value to your local group?

Who are the guest speakers whom you would prefer for the conference?

What adjacent county societies should be invited?

What would be the best hour of the day to begin the clinical conference—3 or 4 p. m., or some other hour—and where would be the best place to secure a good attendance and real interest?

California Medical Association Annual Session:

Have those of your members who could present essays sent the necessary information to the secretary of the pertinent scientific sections (the names and addresses of whose officers are printed in each issue of California and Western Medicine, on advertising page 6)?

Referring to scientific exhibits at the annual session, and to medical or surgical films, members in position to take part in such activities should feel free to write to the Association Secretary for all needed information.

* * *

Concerning Organized Medicine.—Present-day trends permit no evasion of the part organized medicine will play in determining the fate of scientific medicine and medical practice in the days to come.

Thus, a California Legislature recently adjourned. Experience of this and former years leads to only one conclusion, namely, that when the next legislature convenes in January, 1943, problems as grave or perhaps more so, will again confront the profession. Proponents of compulsory health, antivivisection, and similar legislation will assuredly come to the front with their favorite schemes. The defeat of such groups will be more

easily brought about, however, if physicians, through collective and individual effort, will pay attention to certain matters.

Doctors of Medicine too often forget their civic responsibilities. In days gone by, under conditions much different from those of the present, such forgetfulness may have been permissible. But, now, no more. Today the preservation of scientific medicine and standards—and if that be not enough, the instinct of self-preservation, to guard a system of medical practice that will give the best quality of service to patients, and will permit physicians to live according to standards necessary in the profession of medicine—points the way of action for physicians.

How, then, can the joint interests of organized and scientific medicine be best protected? The answer is found in the plan of giving some time at almost every meeting to topics concerned with organized medicine; or if that procedure is not preferred, then by having one, two, or more meetings at which the problems of organized medicine are the major feature.

Among procedures worthy of consideration along this line may be mentioned:

A conjoint meeting, at which members of one or more of the following professions could be invited: medicine, dentistry, law, pharmacy, and nursing; with a program dealing with matters of more or less mutual interest. At such a meeting it would be both a gracious courtesy and a matter of diplomacy to invite as guests the local Senator and Assemblymen, introducing and thanking them for their past coöperation.

The Basic Science Initiative is now before the electorate, and will be submitted at the next state election. The passage of such a law will safeguard healing-art standards in California for years to come, and the aid of every physician and of friends will be needed to put this measure on the statute books. Many questions will be asked by interested patients and other persons. A meeting devoted to this subject will be time well spent.

Medical Service Plans, too, and California Physicians' Service are other subjects worthy of serious thought and discussion. The whys and wherefores of these new plans for meeting current-day inadequacies in medical care should be understood by physicians, especially since laymen are giving much thought thereto. The true facts must be imparted by members of the medical profession if the voters are not to be led astray.

* * *

The above are a few of the matters to which officers and committees of county societies should give consideration. Keep in mind that in such work the Central Office, 450 Sutter, San Francisco, at all times is at the service of members.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 141.

EDITORIAL COMMENT†

ISOLATION OF BLOOD GROUP O SPECIFIC CARBOHYDRATE

According to current clinical logic, Group O human red blood cells are characterized by the absence of A- and B-group agglutinogens rather than by the presence of a positive O-specific antigenic factor. Marked revisions in conventional, clinical logic, therefore, may follow the isolation of O specific haptenes from the gastric juice of patients belonging to the O blood group, which is currently reported by Witebsky and Klendshoj [1] of Buffalo General Hospital, and from the simultaneous demonstration of specific anti-O agglutinins in type A human blood, by Dockeray and Sachs [2] of Trinity College, Dublin.

The specific antigen of type A human blood was detected by earlier investigators [3] in the urine, saliva and gastric contents of group A patients. The "A" substance was first isolated from horse saliva by Landsteiner [4] and shown by him to be a carbohydrate. By a modification of the Landsteiner technic "A" erythrocarbohydrate was afterwards isolated in relatively large amounts from certain commercial peptones,[5] and subsequently shown by Witebsky [6] and his coworkers to be of therapeutic interest. Witebsky found that human O bloods can be completely detoxicated for A recipients by the addition of a few milligrams of "A" carbohydrate. Theoretically, this detoxication is effected by neutralization of the anti-A agglutinins and hemolysins often present in toxic titers in O bloods. Witebsky [7] afterwards showed that "B" erythrocarbohydrate could be successfully isolated from the pooled gastric juice of B patients, and that this specific carbohydrate will completely neutralize B agglutinins in dilutions as high as 1:2,000,000. Therapeutic tests of "B" erythrocarbohydrate, however, have not yet been reported.

Evidence of the existence of a third antigenic component specific for O corpuscles was first obtained from a study of the anti-human agglutinins in animal serums. Normal beef serum [8] and anti-Shiga goat serum [9] both will agglutinate human red blood corpuscles of all types. The A-, B- and AB-agglutinins can be absorbed from such serums

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† This department of California and Western Medicine presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

1 Witebsky, Ernest, and Klendshoj, Niels C.: Jour. Exper. Med., 75:655 (May), 1941.

2 Dockeray, G. G., and Sachs, H.: Jour. Path. and Bact., 52:203 (March), 1941.

3 Brahm, B., and Schiff, F.: Klin. Woch., 5:1455, 1926; 8:5239, 1929; 11:1592, 1932.

4 Landsteiner, K.: Science, 76:351, 1932; Jour. Exper. Med., 63:185, 1936.

5 Goebel, Walter, F.: Jour. Exper. Med., 68:221, 1938.

6 Witebsky, S., Klendshoj, N., and Swanson, P.: Jour. Infect. Dis., 67:188 (Nov. and Dec.), 1940.

7 Witebsky, Ernest, and Klendshoj, Niels C.: Jour. Exper. Med., 72:663 (Dec.), 1940.

8 Greenfield, Gregor: Zeitschr. f. Immunitätsforsch., 56: 107, 1928.

9 Eisler, M.: Zeitschr. f. Immunitätsforsch, 67:39, 1930.

with little reduction in the anti-O titer. Applying such reduced animal serums to clinical cases, Schiff [10] demonstrated the presence of relatively large amounts of O-haptene in the saliva and gastric juice of patients belonging to blood group O. Witebsky currently reports its successful isolation, the substance also being a specific carbohydrate capable of inhibiting the agglutination of human O corpuscles by human isoagglutinins or animal anti-O reagins. Confirming previous clinical experience with "A" and "B" carbohydrates, Witebsky found a wide variation in the amounts of "O" carbohydrate secreted in the gastric juice of different "O" patients, about 25 per cent of them being apparently "nonsecretors." From these nonsecretors, however, a fourth, apparently nonantigenic carbohydrate was isolated, which is immunologically inert when tested against both human and animal hemagglutinins.

That the Witebsky "O" carbohydrate is autoantigenic, is currently reported by the Irish investigators,[2] who found one group A patient whose blood contained relatively large amounts of anti-O agglutinin. This patient's blood was also self-agglutinating, presumably due to the presence of O haptene in the patient's own group A corpuscles. Dahr [11] had previously shown that significant amounts of "O" carbohydrate are also present in Group A erythrocytes.

Attempts to determine the exact chemical nature and interrelationship of the "A," "B" and "O" cytocarbohydrates are now in progress in numerous laboratories. Until this is accomplished, speculative theories of human blood relationships will be of ephemeral, biological and clinical interest. It is evident, however, that a purely negative rôle can no longer be assigned to human O-group erythrocytes.

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MORE CONCERNING RHEUMATIC HEART DISEASE

II*

The truly dangerous medico-social problems of this age do not advertise themselves and clamor for solution. Like the iceberg, they give only a hint of their true dimensions. The control of such problems waits on the tedious and difficult work of determining their exact nature and extent.

Rheumatic heart disease appears to be such a problem. Statistical studies made in various sections of the country give some indication of the great numbers of children affected by the disease. These studies correspond to the small, visible portion of the iceberg. What lies beneath the surface?

Without doubt there are a large number of children with rheumatic infections who are not included in any statistical studies, and who have not reached the attention of physicians. Rheumatic infection may exist completely unrecognized for years. Insurance and other health examinations have revealed rheumatic heart disease in adults who were completely unaware that they had ever had rheumatic fever. The problem is further complicated by the fact that, owing to its protean clinical manifestations, rheumatic fever may be extremely difficult to recognize. Hedley says "The disease tends to become a smoldering low-grade infection, with periods of reactivation or recrudescences."

Ethel Cohen says: "For some children, several examinations in the clinic will be needed. When the diagnostic problem is more difficult, hospital care will be required for close observation, for additional laboratory tests, and often for the opinion of other consultants. A correct diagnosis is of the utmost importance. Years of invalidism for children, and worry and financial strain for their families, can be prevented if the fact can be established that no disease exists."

To make this disease reportable is only a step in the long preventive campaign, but it is a step which must be taken before any real progress can be made. The hidden cases must be uncovered—and we can assume that there are many hidden cases and that they will be difficult to detect.

Then, and only then, can we apply the medical and administrative techniques, which have so successfully brought tuberculosis under control, to this disease which is recognized as one of the most serious problems of national health today.

University of California Hospital.

Amos Christie,
San Francisco.

CAUSE OF DEATH IN CORONARY THROMBOSIS

Coronary thrombosis is recognized as a sufficient and valid cause of death by vital statisticians, but in reality it is not per se a cause of death. At any rate, it does not by itself explain the modus operandi of the termination of life.

Following myocardial infarction, death may follow directly from five distinct conditions, each a direct result of the infarction: Shock; ventricular fibrillation; acute heart failure (acute dilatation); embolism, following mural thrombi; or cardiac rupture.

Shock is distinctly an early phenomenon in coronary thrombosis. In some instances, practically no shock is present, in others it is very severe, probably varying with the size of the infarct. As in surgical shock, the patient either dies or recovers from it in a short time, usually a matter of a few hours or at most a day or two.

Ventricular fibrillation is one of the most, if not the most dreaded condition complicating cononary thrombosis, since it is incompatible with life for more than a very few minutes at most, and since there is practically no treatment for it after it devel-

10 Schiff, F.: Zeitschr. f. Immunitätsforsch., 82:302, 1934.
11 Dahr, Peter: Zeitschr. f. Immunitätsforsch., 92:180, 1938.

* For Article I of this series, see August issue, on page 58.

ops except, perhaps, intracardiac injections. Some of those patients supposedly dying of shock, and many of those who die suddenly, as during sleep, probably go out this way. This condition may occur at any time during the course of the disease.

Acute cardiac failure can intervene during the course of coronary thrombosis with or without congestive failure, and the patient dies in this manner, i. e., with muscle failure, dilatation and eventual cardiac standstill. Such a termination is greatly hastened if one of the tachycardias occurs. With such failure there may also develop a terminal ventricular fibrillation.

Mural thrombi, starting on the endocardial surface of the infarct, are common, particularly in the left ventricle. Emboli from detached pieces of these thrombi go into the systemic (or pulmonary) circulation, and will cause death if they reach vital areas.

Cardiac rupture is not very common, and is a late occurrence during the second or third weeks usually, the reason being, of course, that the infarct has degenerated sufficiently to cause a weak area in the wall, and scar tissue replacement has not yet gotten sufficiently firm to hold the strain put on it. Such patients do not always die suddenly. Some have been known to live for several days after rupture, and they do not die from hemorrhage, but from compression of the heart by blood in the pericardium. Cardiac aneurysm results, at times, from a weakened myocardium over the area of infarction, and may rupture later. Such an aneurysm is one cause of chronic cardiac invalidism following infarction.

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VITAMIN BLOCKADE

It is currently reported by György and Rose [1] of Western Reserve University, working in coöperation with Eakin, Snell, and Williams of the University of Texas, that uncooked egg albumin is sufficiently undigestible and has a sufficiently high selective affinity for certain essential vitamins as to prevent adequate vitamin absorption from the gastro-intestinal tract and thus cause lethal avitaminosis. In their opinion, this finding adequately explains the well-known "toxicity" of raw egg, and represents a principle commonly ignored by dietitians.

Thus far "vitamin blockade" has not entered into clinical logic, except in sprue and other chronic diarrheas and in cases of vitamin deficiency due to long-continued habitual use of mineral oil laxatives. About fifteen years ago, it was shown by Burrows and Farr,[2] for example, that the addition of 7 per cent mineral oil to a well-balanced diet will kill rats within two weeks, with typical symptoms of vitamin A deficiency. A reduction of the dosage to 1.3 per cent, the approximate therapeutic dose per kilogram of body weight often prescribed for children, is almost equally toxic for rats, death, however, usually being postponed till the end of the third week. It was subsequently shown by Smith and Spector [3] that mineral oil also prevents the intestinal absorption of vitamin D.

Somewhat greater interest in interference with vitamin absorption has been shown by veterinarians. It has long been a practice of poultry raisers, for example, to add charcoal to poultry feeds, under the impression that charcoal adsorbs bacterial toxins and other putrefactive products, and thus improves health and reduces mortality. It is recently alleged by Almquist and Zander [4] of the University of California, however, that the addition of charcoal to otherwise adequate diets almost invariably leads to multiple avitaminosis. The California dietitians placed large numbers of one day old chicks on a basal diet, containing optimum amounts of vitamins A, K, D, G and the "chick gizzard factor," but without the considerable excess or "margin of safety" found in many commercial chick mashes. The addition of 2 per cent adsorbing charcoal to this basal diet reduced the average weight of 34 day old chicks to 181.3 grams, as contrasted with 294.6 grams in the control noncharcoal group. Seventy-five per cent of the charcoal-stunted chicks showed typical and well-marked paralyses, incoördinations and keratinizations of the nictating membrane, all cases recovering after daily oral administration of vitamin A in fish oil. Severe vitamin K deficiency was also noted in most of the charcoal-fed chicks, shown by multiple subcutaneous hemorrhages, and a prolonged blood-clotting time. The accompanying "gizzard factor" deficiency was shown by severely eroded gizzard lining. Ten per cent of the charcoal-fed chicks also developed "curled-toe paralysis," which was promptly cured by the oral administration of synthetic riboflavin.

The "toxicity" of raw egg was described twenty-five years ago by Bateman.[5] In his hands, rats fed an adequate and well-balanced ration except for a large proportion of raw egg as the source of protein, developed a peculiar and progressive dermatitis, accompanied by a gradually increasing emaciation which eventually proved fatal. Similar toxic symptoms were afterward demonstrated in the chick, guinea pig, rabbit, monkey, and dog. It was later found that slightly cooked fresh egg and commercial dried eggs are equally toxic. Fractionation of the egg white soon led to the conclusion that the deleterious factor is a toxalbumin, somewhat analogous to snake venom and other zoötoxins. A purposeful protective rôle was assigned to this toxic factor by speculative biologists.

Parallel with this chemical research there was the discovery that coctostable aqueous extracts of yeast, and of different vegetable and animal foods, are often able to prevent or cure egg-white injury.

1 György, P., Rose, C. S., Eakin, R. E., Snell, E. E., and Williams, R. J.: Science, 93:477 (May 16), 1941.

2 Burrows, M. T., and Farr, W. K.: Proc. Soc. Exper. Biol. and Med., 24:719, 1927. Dutcher, R. A., et al.: Jour. Nutrition, 8:269, 1934. Curtiss, A. C., and Hornton, P. B.: Amer. Jour. Med. Sci., 200:102, 1940.

3 Smith, M. C., and Spector, H.: Jour. Nutrition, 20:19, 1940.

4 Almquist, H. J., and Zander, D.: Proc. Soc. Exper. Biol. and Med., 45:303 (Oct.), 1940.

5 Bateman, W. G.: Jour. Biol. Chem., 26:263, 1916.

These natural antitoxins were first described by Boas[6] as "protective factors X" and afterward named "vitamin H" by György.[7] It has been recently shown, however, that "vitamin H" is identical with biotin.

Applying the newer microbiological techniques, it is currently shown by the Cleveland-Texas cooperative group that fresh egg albumin is capable of inactivating biotin *in vitro,* due to the formation of a stable and relatively undigestible biotin-albumin conjugate. György and his colleagues have tentatively suggested the term "avidalbumin" (literally, "hungry" or "vitaminophagic" albumin) for this biotin-binding protein. They believe that its biotin-binding capacity is an adequate explanation for the apparent "toxic" effects of raw egg. This was adequately verified by animal experimentation. Microbiological assays of the tissues of egg-white injured animals, for example, invariably showed a marked deficiency in tissue biotin, in spite of the fact that more than adequate amounts of biotin were present in the gastro-intestinal tract. Intestinal absorption of nutritional biotin was apparently completely blocked. Or, if minor absorption did take place, it was in the form of a biologically inert biotin-albumin conjugate. The "toxic" effects of egg white are thus merely secondary effects due to fractional (biotin) tissue starvation.

György and his colleagues have thus suggested a new principle in nutritional pathology which, in time, may be shown to have numerous other clinical applications. Popular apprehension, however, should be prevented at this time by emphasizing the fact that egg white loses its "toxicity" on adequate cooking,[8] and that cabbage, spinach and many other vegetables, as well as liver, kidney, and cow's milk, have high prophylactic and curative values. Summer milk is superior to winter milk in this regard, though both are effective with experimental animals. Meanwhile, biological theorists may be puzzled to assign a teleological rôle to this biotin-binding protein.

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6 Boas, M. A.: Biochem. Jour., 21:712, 1927.
7 György, P.: Z. ärztl. Fortbild., 28:377, 417, 1931.
8 Parsons, H. T., and Kelly, E.: Amer. Jour. Physiol., 104:150, 1933.

In California one of the first local health regulations was passed in San Francisco which prohibited the shooting of buzzards and other birds that might consume carrion. In Sacramento, in 1850, an ordinance was passed which required the daily removal of garbage, waste, and refuse. The epidemic of cholera that invaded Sacramento in 1850, and again in 1852, was the factor that caused the early passage of this legislation.

The most common nuisances reported to health officers are odor nuisances. To be sure, very few, if any odor nuisances, are detrimental to individual health, although they may constitute offenses to the senses, and may be very disturbing to the comfort of the individuals concerned.

ORIGINAL ARTICLES

LEUKEMIA: EVALUATION OF THE THERAPY*

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Introduction and Definition.—The term "leukemia" signifies a pathologic condition characterized by dysplasia of the hematopoietic tissues, often with evidences of widespread metastases and tumors in distant organs, and usually with the striking feature of a leukocytosis of immature cells in the peripheral blood. In so far as the bone marrow is concerned, it is usually hyperplastic and, in some instances, the leukemic process may manifest itself as a true tumor of the hematopoietic tissues. The immature circulating leukocytes in the blood stream are to be considered permanent metastases. Leukemia simulates cancer in the following ways: the leukemic cell loses its ability to mature (growth proceeds uncontrolled); there is a tendency to form secondary metastatic foci; the metabolic rate of the immature cells is similar to that of neoplasms; the cells maturate under the influence of roentgen irradiation; the disease is not transmissible by inoculation; and, finally, like cancer, the clinical course is marked by cachexia and a fatal termination. The leukemic reaction in the bone marrow and lymph glands is in all probability initiated by chemical changes in the body fluids, which bathe these vulnerable tissues and their definitive cells.

The incidence of leukemia is increasing out of all proportion to the facility of its diagnosis. During this past spring, unusual and bizarre clinical types of leukemia have been quite common. One wonders what part alterations in the diet, the habitual use of powerful medications (often self-prescribed), and the sinister attack of the virus diseases play in these unusual reactions. Clinically, leukemias differ in their degree of malignancy. Some types of leukemia react like fixed tissue tumors and produce distress by mechanical pressure, while other types freely invade the distant tissues. Some are held in abeyance by careful treatment, some remit spontaneously, and some appear to exhibit the characteristics of infections. Often an infection may stimulate the marrow to the point of provoking leukemia.

In order to facilitate the discussion of the treatment of leukemia, it seems advisable to give a simple classification of the clinical forms of the disease. Fatigue, enlarged lymph glands, splenomegaly, hepatomegaly, and an increased tendency to bleed are the cardinal signs of leukemia.

CLINICAL TYPES OF LEUKEMIA

1. In the purely hematologic variety, the diagnosis may be made incidental to a routine blood count, the patient being totally unaware of the dis-

* From the Department of Medicine, University of California Medical School, San Francisco.
Read before the Section on General Medicine at the seventieth annual session of the California Medical Association, Del Monte, May 5-8, 1941.

ease or any of its symptoms. This form is not uncommon. Often the precise diagnosis is not easily determined because of the difficulty in differentiating leukemia from the myeloid reactions secondary to infections.

2. A second variety of leukemia is characterized by an increased basal metabolic rate, with symptoms of fever, tachycardia, hyperidrosis, loss of weight, nervousness, weakness, minor gastro-intestinal symptoms, and cachexia.

3. A third variety is characterized by enlargement of abdominal viscera (liver and spleen) with or without lymphadenopathy. Here the symptoms are referable to the enlarged organs and to the mechanical difficulties they produce, such as pressure, pain, cough, urinary frequency, diarrhea or constipation, occasionally arthritis, and not infrequently neuritis.

4. A fourth variety is characterized by anemia, weakness, and signs of myocardial insufficiency. Here the symptoms are due to the effects of the decreased oxygen-carrying capacity of the blood. The cardinal symptoms are pallor, weakness, dizziness, fatigue, and edema.

5. A fifth variety is characterized by an abnormal tendency to bleed and occasionally by thrombosis. Usually the signs and symptoms of this variety connote an advanced stage of one of the other forms of the disease.

The variations in the intensity and clinical character of the leukemic disease process, in a given individual, suggest that perhaps the nature of the stimulating agent, as well as the biologic characteristics of the host, conditions the type of the disease.

Since there is no known method of cure, all treatments of leukemia should be regarded as empirical and have as its objective the symptomatic relief of the patient. Furthermore, it is not justifiable to institute practices which may throw out of equilibrium the general tissue defense mechanisms of the body. A greater measure of success will come to him who pays particular attention to the minor details of treatment.

GENERAL MEASURES OF TREATMENT

Since the patient afflicted with leukemia suffers from weakness and lack of energy, due primarily to the anemia, rest and limitation of activity should be prescriptive. He should be taught to live within his physical capital. The presence of a high basal metabolic rate, of fever, or of enlargement of the liver and spleen, conditions not only the activity of the patient, but also determines the character of the treatment. Naturally, the diet should be well balanced, high in calories, and high in carbohydrate. In lymphatic leukemia, a diet of low fat content should be prescribed in order to avoid stimulation of the lacteal and lymphatic systems. When diffuse bleeding from mucous surfaces occurs, it is advisable to give a diet ample in vitamin C and high in fat and protein in order to obtain the maximum beneficial effects on the capillaries and on the blood coagulation mechanism. In so far as climate is concerned, undue exposure to sunlight should be discouraged. Patients suffering from leukemia should be advised to avoid sunburn. The oral hygiene of the leukemic patient should be scrupulous, since oral sepsis is common in this disease. The use of a soft toothbrush, sodium perborate, hydrogen peroxide, and, occasionally, warm sodium bicarbonate solutions are advised. For breaks in the mucous membrane, a one per cent aqueous solution of gentian violet may be used, and there are advantages to be gained in the routine use of astringent mouth washes.

Since the treatment of the patient with leukemia is primarily symptomatic, it would seem advisable to list the criteria upon which the selection of cases for treatment is based. Consider treatment:

1. When the leukocyte count is over 200,000, and institute it when the count is over 400,000. Do not treat the leukocytosis alone.
2. When the effects of mechanical pressure produce symptoms.
3. When there is a marked and progressive anemia.
4. When weight loss is a prominent factor, and especially when it is due to gastro-intestinal dysfunction.
5. When there are hemorrhagic manifestations.
6. When the temperature remains elevated.
7. When the basal metabolic rate is high.

THERAPEUTIC AGENTS IN THE TREATMENT OF LEUKEMIA

1. *Biologic Agents.*—Capps and Smith (1907) demonstrated the presence of leukocytolytic substances in the serum of treated leukemic patients. These substances were capable of destroying leukocytes *in vitro* and of producing leukopenia when injected into animals. When given to patients, they produced only transitory diminutions in the leukocyte count. Immune substances are ineffective in the treatment of human leukemia, although they may be of value in the treatment of the virus leukemia of fowl. The use of Coley's toxin (streptococcus and prodigiosus) is warrantable in the treatment of Hodgkin's disease, although its effectiveness may be attributed to the foreign protein reaction which it produces. Inoculation of the leukemic patient with malaria plasmodia is not defensible on the evidence so far presented, despite the fact that it produces fever, leukopenia, and retardation of the activity of the bone marrow. Extracts of liver, spleen, bone marrow, lymph glands, and fetal tissues are too variable to be classed as effective therapeutic agents, although there is some evidence to show that, perhaps, liver extract may have a limited use in the treatment of leukemia. Transfusions are useful in the treatment of leukemia when hemorrhage threatens life and when marked anemia is present. When anemia is accompanied by leukopenia, and under circumstances when the use of irradiation is prohibitive, transfusion remains the only rational therapeutic measure.

2. *Chemical Agents.*—Arsenic, introduced by Lissauer in 1865, and its allies, antimony, bismuth and phosphorus, are perhaps the most effective chemotherapeutic agents for the treatment of leukemia. Arsenic is especially valuable in the

treatment of early cases of myeloid leukemia. Frequently it helps postpone treatment by irradiation, thereby prolonging the period of survival. Although arsenic is of some value in the treatment of chronic lymphatic leukemia, it is most effective in the treatment of chronic myeloid leukemia. One should give arsenic in rapidly increasing doses until toxic symptoms occur, and thereafter continue the maximum tolerated dose until the leukocyte count drops to normal levels. Subsequently the dosage may be diminished to the minimum, and it is my belief that the leukemic patient should never discontinue its use. In the treatment of chronic myeloid leukemia with arsenic, one may expect symptomatic improvement, remission of the leukemia, a decrease in the leukocyte count, a reduction in the number of immature leukocytes and nucleated red blood cells in the blood stream, and a decrease in the size of the spleen, liver, and lymph glands.

The average dose of arsenic, as Fowler's solution, is three minims, three times a day, increasing by one minim per dose per day to a maximum of 12 to 15 minims three times a day, then reducing the dose by one minim per dose per day and continuing in cycles until the desired effect is obtained. The maintenance dose of Fowler's solution may be established at levels as low as 2 to 3 minims, two to three times a day. Some hematologists give the maximum tolerated dose until the leukocyte count is reduced to normal levels before reducing the dosage.

The toxic symptoms of arsenic therapy are chemosis, coryza, pseudo-erysipelas, urticaria, gastro-intestinal symptoms (irritation, nausea, vomiting, and diarrhea) herpes, neuritis, hyperpigmentation, and hyperkeratosis. Therefore, patients taking arsenic should be carefully observed for signs of toxicity. Occasionally arsenic therapy, combined with irradiation therapy, is found to be the best treatment in chronic myeloid leukemia.

As noted above, antimony, bismuth and phosphorus belong to the same chemical group as arsenic. All of these agents induce leukopenia and depress the erythropoietic tissues. Antimony, however, exhibits the least toxic effect on the erythropoietic function of the marrow. It is less effective than arsenic in reducing the size of the spleen, liver, and lymph glands. Soon radio-active compounds of antimony, arsenic, and bismuth may be available, so that the effects of these agents may be compared with those of radio-active phosphorus which will be described below.

Another potent agent in the treatment of leukemia is benzol, introduced by Koranyi in 1912. A 50 per cent solution in olive oil is given orally in capsules in doses of 3 to 5 grams a day. Benzol is a powerful but highly toxic drug, capable of producing aplasia of the marrow. The use of benzol should be discontinued when the white blood cell count drops to 20,000. Benzol may be used as an adjuvant to irradiation therapy, and it may prove effective in the x-ray fast case.

Friedgood (1932) reintroduced the use of Lugol's solution to alleviate the symptoms secondary to an elevated basal metabolic rate in chronic lymphatic leukemia. My own experience corroborates the observations of Friedgood.

The alkaloidal active principle of meadow saffron (Colchicum autumnale), colchicine, has been effectively used by some workers to arrest the growth of developing tumor cells at the metaphase. It is easy to destroy tissue, but to destroy differentially is a difficult problem, and it appears that in colchicine we have an agent to assist us in this problem. At certain critical concentrations of colchicine in living tissues, Dixon found that the mitosis of developing cells was accelerated up to the stage of the metaphase, at which point it was subsequently arrested and the cells failed to develop further. From this information it would appear that colchicine would be most effective in the treatment of those leukemias characterized by markedly increased numbers of primitive blast cells. The recommended dosage of colchicine is one-half milligram, three times a day, and increasing the dose by one-half milligram daily up to the point of toxicity. The effective tissue concentration of colchicine is given as 1 to 8,000,000. Colchicine is highly toxic, and symptoms such as salivation, nausea, vomiting, gastric pain, diarrhea, and weakness have been recorded with doses of 4 to 5 milligrams. I have not observed any dramatic effects in the treatment of chronic leukemia, perhaps owing to the fact that the cells are already too highly differentiated. It appears to be indicated in the treatment of acute leukemia, because of the increased rate of development and the degree of immaturity of the blast cells in this disease. It would be logical to use colchicine in those leukemias in which the proportion of blast cells is high and in which irradiation therapy is desirable.

There are some reports concerning the use of quinin in the treatment of leukemia. This medicament depresses leukocytopoiesis; however, it is less effective than arsenic.

Colloidal gold, silver, sulphur, and lead have also been used. These agents produce an effective leukopenia, but they are dangerous in that they may induce malignant leukopenia, bone marrow aplasia, or fatal purpura.

Other chemical agents, such as ergot, sodium sulfocyanate, cinnamic acid, naphthalene-tetrachlorid, amidopyrin, neocinchophen, and members of the para-aminobenzenesulfonamid group have been used. In some individuals these will produce transient diminutions in the leukocyte count. The use of iron for the treatment of leukemia is not defensible, although it may be effective in the treatment of the anemia of some leukemias.

3. *Physical Agents.*—Since the life expectancy of the patient with leukemia is roughly three and a half years, it behooves us to advance carefully, keeping in mind that at best our therapy is a compromise. We must remember that even normal man may be rendered more susceptible to the spontaneous occurrence of leukemia after exposure to roentgen-rays. Contrary to the opinion of many, chronic leukemia may often be converted into acute leukemia by irradiation or infection. Infections, by and large, prove devastating to the leukemic

patient; this may be due in part to the fact that the leukemic organism does not produce immune bodies effectively. I have never seen a leukemic patient benefited by an intercurrent infection—quite the contrary, it has usually proved disastrous.

Roentgen Irradiation.—To date, the gamma ray has proved to be the most effective and universal therapeutic agent in leukemia. Senn (1903) was the first to treat leukemia with x-ray. Fundamentally, irradiation aims to destroy tissue; ideally we wish it to destroy selectively the offending cell.

Although the mechanism of the effectiveness of irradiation in the treatment of leukemia is not known, there is some evidence to show that the beneficial effects are brought about by hastening the maturation of cells. Isaacs (1926) demonstrated that small to moderate doses of x-rays are stimulative and that, whereas the differentiated cells—myelocytes and lymphocytes—are stimulated to hastened maturity since they have lost their normal power of cell division, the myeloblast and the lymphoblast are stimulated to increased multiplication because they have not yet acquired the ability to maturate normally.

The General Indications for Irradiation Therapy. Each case is a law unto itself, and the best results are obtained by close coöperation between hematologist and roentgenologist. When pressure symptoms, exceedingly high leukocyte counts, or evidences of progressive invasion of the bone marrow occur, it is necessary that roentgen-ray therapy be instituted. Naturally, one must be guided by the character of the disease, the size of the splenic tumor, the blood counts, the general condition of the skin and capillaries, and the general appearance and well-being of the patient. It must be remembered that the patient may live in harmonious equilibrium with his disease, and that the physician should aim to assist in its active combat, thereby bending every effort toward enhancing the active defense mechanisms. The control of leukemia is exceedingly difficult when the tissue reactions of the host are purely passive. Furthermore, leukemia becomes more and more resistant with each course of irradiation. The reward for too vigorous treatment is a short remission and a more rapid recurrence. It is advisable to use small, fractional doses of irradiation, and the least total dose which will produce an effective remission. By the use of small doses, too rapid regression of leukemic deposits, and marked and unintended reactions are avoided. It should be remembered that some hosts do not take irradiation well, and, conversely, that some leukemias are particularly sensitive. It is well to remember that the total effective dose of irradiation in any given case is fixed, and, therefore, it should be used sparingly, carefully, and wisely.

The site of treatment in leukemia will depend upon the type. In myeloid leukemia, it is logical to treat the bone marrow or an enlarged organ, known to contain the offending cells in active growth. The effects of local treatment are reflected throughout the body. Irradiation of the spleen alone in myeloid leukemia is usually adequate, and aside from the specific effects there is an unexplained "excellent general effect." This is attributed to the fact that the large volume of blood circulating through the lungs and heart is also irradiated.

In lymphatic leukemia it is logical to irradiate the enlarged lymph nodes, then the spleen and eventually the bone marrow. The lymphatic infiltrations of the bone marrow do not, as a rule, regress following irradiation to other parts of the body; therefore the roentgen rays must be directed to the bone marrow when it is known or suspected that lymphatic infiltrations exist there.

When anemia is a disturbing factor during the course of treatment of leukemia, it is advisable to irradiate the long and flat bones. Duke (1923) advocates irradiation of the chest in order to affect the greatest volume of blood, concluding that the important systemic effects are mediated through the surcharged irradiated blood. Dale (1931) advises treating the entire body. This method has proved quite useful in the treatment of certain refractive cases of lymphatic leukemia.

In roentgen irradiation do not aim to reduce the leukocyte count to normal. An increase in the hemoglobin and red blood cell content indicates that irradiation is effective. Conversely, a marked drop in hemoglobin and red blood cell content indicates an unfavorable reaction or overirradiation. In lymphatic leukemia it may be necessary to treat the bone marrow if the hemoglobin and red blood cell content remain unaltered after the leukocyte count has dropped and the lymphadenopathy and splenomegaly have regressed, although the general clinical condition of the patient is perhaps the most important single guiding factor in the treatment.

Discontinue irradiation therapy when there is:

1. A too rapid decrease in the leukocyte count.
2. Reduction in the hemoglobin and red blood cell content during treatment.
3. Increasing numbers of primitive blast cells in the peripheral blood.
4. Evidence of decreasing vitality.

Other forms of gamma irradiation therapy, such as radium, are not justifiable unless roentgen therapy is not available, or the patients cannot be moved to hospitals.

Radio-active Phosphorus.—The use of beta rays (radio-active phosphorus) in the treatment of leukemia is still in its infancy. It is possible that soon great advances may be forthcoming. Radio-active phosphorus, like ordinary phosphorus, localizes in the bone marrow; therefore we have a means of bringing potent beta rays to the point of active formation of the pathological cells, especially in myeloid leukemia. In general, radio-active phosphorus is distributed and deposited throughout the marrow. It has a tendency also to seek leukemic infiltrations elsewhere in the body. Another interesting fact is that the leukemic patient exhibits a more rapid uptake of radio-active phosphorus than the normal person. The biologic phenomena of phosphorus and the peculiarity of the physical characteristics of radio-active phosphorus make available for us a potent weapon in the treatment of leukemia. The future should bring us definite and much-desired information on this therapeutic agent.

AXIOMS IN THE DIAGNOSIS AND TREATMENT OF LEUKEMIA

It is possible from the above discussion to formulate a few of the aforementioned principles as axioms:

1. The blood should be counted before, and at frequent intervals, during the active treatment of leukemia.

2. Do not treat a leukocytosis.

3. Cutaneous lesions are of diagnostic importance, since they are more common in Hodgkin's disease and lymphatic leukemia than in myelogenous leukemia.

4. Purpuric hemorrhages and petechiae suggest advanced stages of leukemia, in contrast to the sudden hemorrhages from the mucous membranes and oral cavity in acute leukemia.

5. The appearance of infiltration of the retinae, or of palpable lymph nodes, in the course of myeloid leukemia is decidedly unfavorable. It connotes a terminal stage of the disease.

6. The anemia in leukemia is due to the leukemia. It is usually alleviated in the course of treatment; if not, the prognosis is grave.

7. A high blast count is an unfavorable sign, especially when it occurs in the course of x-ray therapy.

8. An early death in the course of lymphatic leukemia is usually due to infection, because the myeloid cells (phagocytes) are depressed or absent.

9. Do not biopsy tissues unless it is absolutely necessary, because the leukemic processes at the site of the incision may become aggravated.

10. It is advisable to reserve irradiation for the treatment of mechanical disturbances arising in the course of leukemia.

11. Irradiation appears to hasten the fatal course of acute leukemia.

12. It is more valorous to be conservative in the treatment of acute leukemia. It is rarely benefited by any sort of treatment.

13. Our most hopeful therapeutic agents are, at best, only palliative measures.

14. As a rule it is advisable to irradiate the spleen and liver in myeloid leukemia, and the lymph nodes in lymphatic leukemia.

15. The bone marrow may be advantageously irradiated for the persistent anemia in the course of chronic lymphatic leukemia.

16. The lymph nodes appear to withstand more irradiation, without general constitutional reactions, than the spleen.

17. Massive doses of roentgen irradiation produce edema and swelling before decreasing the size of a leukemic tumor. This phenomenon may prove disastrous in the treatment of tumors around the delicate mediastinal structures.

CONCLUSIONS

1. There is no known method of cure of leukemia.

2. It is advisable to outline a conservative plan in the treatment of leukemia, and to attempt to understand the biologic reactions of the individual unit acting as a whole in his environment.

3. The goal of successful therapy in leukemia is the temporary restoration of the patient to a degree of efficiency, enabling him to live a useful though limited life.

4. At present, irradiation is the best single therapeutic agent in the treatment of leukemia.

5. Arsenic and radio-active elements offer a ray of hope in the chemotherapeusis of leukemia.

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SULFONAMIDE GROUP OF DRUGS: GENERAL PROPERTIES, USE AND DOSAGE*

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INTRODUCTION.—Almost five years have passed since the introduction of the sulfonamides into this country. They have been used on an unprecedented scale, and a tremendous wealth of material and reports has accumulated. Many drugs have been developed; only a few, however, have gained sufficient recognition to be included in our review. We shall concern ourselves with sulfanilamide, sulfapyridine, and sulfathiazole. Even this limitation will not make it possible to cover the field adequately. The following speakers will take up the applications in their respective fields, and Doctor Cutting, I hope, will stress in his discussion the pharmacologic principles. Therefore, I take the liberty to restrict my remarks to certain general principles which seem important at this time, and which constitute a present trend as it appears to us. The price for the required brevity of this presentation is a somewhat dogmatic character of my remarks, for which I want to apologize.

HISTORY

It is well known now that sulfanilamide was synthesized and described in 1908. Its chemotherapeutic properties, however, were not adequately appreciated until sufficient interest was awakened by the reports about prontosil as developed by the German workers around 1932-1934. In 1935, French investigators were able to demonstrate, in extensive animal experiments, that the chemotherapeutic results of prontosil could also be obtained with a simpler radical, contained in the complex prontosil molecule. This radical, sulfanilamide, reached the United States in 1936 at the same time as did prontosil. The latter was mainly used in conditions where sulfanilamide could not be given by mouth, while prontosil was available in a sterile stable solution.

In 1938, sulfapyridine was developed in England and gained rapid recognition as a potent agent against pneumococci and, to a lesser degree, against staphylococci. It proved, however, to be a much more toxic drug than sulfanilamide. It is for this reason that sulfathiazole, which was developed in this country in 1939, attained widespread popu-

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* Read before the Section on Eye, Ear, Nose and Throat at the seventieth annual session of the California Medical Association, Del Monte, May 5-8, 1941.

larity when it was shown that it was therapeutically equal to sulfapyridine, but much better tolerated.

ACTION

Briefly, the sulfonamide drugs are apparently bacteriostatic. It could be shown *in vitro* and *in vivo* that an inhibition of bacterial growth is produced, possibly by the interference with metabolic functions, although the nature of this mechanism is largely obscure. Under certain circumstances even bactericidal action—that is, killing of the organisms—may be obtained. Quite frequently, complete eradication of pathogenic organisms is not achieved even in the case of clinical recovery. It is necessary for the production of a satisfactory result that the drug reaches the bacteria, that they are susceptible to its action, that the concentration of the drug is adequate, and that the defense mechanism of the host is capable of taking care of the remaining organisms. In foci such as thrombi, which the drug does not penetrate, or abscesses where substances interfere with the action of the drug, no effect may be expected. It is in the tissue, which is affected by the infection, but not yet destroyed, where the drug exerts its optimal action. The drug prevents spreading and generalization of the infectious process and promotes localization. Therefore, surgical principles must be considered just as in the absence of chemotherapy. The same is true for bacteriologic studies, which should not be neglected in view of the relatively selective action of some of the compounds. For the demonstration of organisms by culture during the course of chemotherapy, media should be used to which para-amino-benzoic acid has been added. This substance will neutralize the bacteriostatic action of the drug contained in the specimen without interfering with the growth of any bacteria.

CHOICE OF DRUG

For a long time sulfanilamide was the drug of choice; sulfapyridine, and later sulfathiazole, were recommended in pneumococcus and staphylococcus infections and in all conditions in which the response to sulfanilamide had not been satisfactory. In this connection, I would like to point out certain misunderstandings commonly encountered. There is a widespread association between sulfanilamide and hemolytic streptococci, sulfapyridine and pneumococci, and sulfathiazole and staphylococci. This is due to their chronologic order, but it is quite misleading. In the development of prontosil and sulfanilamide it could be shown that they were active experimentally *in vitro* and *in vivo* against a variety of pathogenic organisms; in other instances, as in gonococcus infections, the clinical use preceded experimental investigations. When, later, other drugs were synthesized and tested, it was demonstrated that they were active not only against a variety of organisms, including those susceptible to prontosil and sulfanilamide, but also against others, as in the case of sulfapyridine against pneumococci. In the beginning, however, clinical studies were available only in those diseases where sulfanilamide had not been active or satisfactory. So there accumulated rapidly a literature about the use of sulfapyridine in pneumococcus, staphylococcus, and gonococcus infections; but at the same time no studies of larger groups were available in erysipelas and other hemolytic streptococcus infections.

This was largely accentuated by the fact that sulfapyridine was often producing most unpleasant subjective and objective reactions.

In the beginning of sulfathiazole medication it was mainly used as a substitute for sulfapyridine. Later, however, its use has become more and more extensive, until it now includes very frequently conditions in which, previously, sulfanilamide has been used exclusively.

The preceding remarks cover the initial choice of drug. It has become our practice to discontinue any of the drugs if some apparent effect cannot be demonstrated within two to three days. As it may be possible that we are dealing with a nonsusceptible or drug-fast strain which might be susceptible to one of the other drugs, those should be tried.

Considering the wide range of chemotherapeutic activity and the relatively low toxicity of sulfathiazole, I am personally inclined at the present time to recommend sulfathiazole as the drug of choice.

INDICATIONS

As the following speakers of this symposium will take up this problem in their respective fields, it should suffice to emphasize here that indications have become broader and broader, even including many conditions where the etiology has been by no means established. The fact that the drugs might possibly be of benefit is coming more and more into the foreground. Although we have to remember that all these drugs are potentially harmful and that their use presents a certain hazard, we have learned, on the other hand, to minimize this hazard by the recognition of danger signals which we shall discuss in the paragraph dealing with the toxic reactions.

It has become more and more a matter of judgment of the physician in the individual case, with careful consideration of the potential dangers of the underlying conditions weighed against the toxicity of the drugs; no hard-and-fast rule will relieve the physician from the burden of this decision.

CONTRAINDICATIONS

There is, strictly speaking, only one contraindication—intolerance to the drug. This might be inherent or more often acquired. In this respect it seems to be imperative that each patient should be carefully informed during or after the course of chemotherapy which drug he has received, how much of it, over what period of time, and whether he has shown toxic reactions indicating a possible intolerance. On the other hand, each patient should be questioned in detail about medication in the past, as the widespread use of these drugs makes it more and more likely that any patient might have experienced previous medication.

It seems wise to test these patients, if possible, with a small dose, and to give larger doses only if alarming toxic reactions do not occur.

TOXIC REACTIONS

The following reactions are grouped according to their severity and the corresponding recommendation of discontinuation:

Mild reactions: Medication may be continued, but watchfulness is necessary.

Malaise	Constipation
Headache	Moderate cyanosis
Giddiness	Chilliness
Muscular weakness	Palpitation
Loss of energy	Slight dyspnea
Nausea	Mild urticarial rashes
Anorexia	

Moderate reactions: Continuation is justified only if underlying conditions warrant it.

Vomiting	Extensive rashes
Diarrhea	Edema
Prostration	Marked cyanosis
Mental changes	pallor
Fever	dyspnea

Severe reactions: Medication to be discontinued, except in rare selected conditions:

Destructive blood changes	Toxic jaundice
Marked leukopenia	Toxic nephritis
Agranulocytosis	Hematuria
Hemolytic anemia	Anuria
Extensive purpuric rashes with high fever	Peripheral neuritis

Medical supervision during the course of chemotherapy should be mandatory. The control of blood and urine cannot be overemphasized, notwithstanding the recognition of economic difficulties in many instances. There is no doubt that patients experience less severe toxic reactions if they are confined to bed, or at least to their home and also kept from work. But here, as in so many phases of medicine, the physician has to reach a decision on the merits of the individual case. If chemotherapy seems indicated, it should not be lightly dismissed, because not all rules of precaution can be satisfied.

PROPHYLACTIC USE

Experimental work has shown again and again that the prophylactic and protective actions of these drugs are far superior to their therapeutic action. The reason becomes quite evident from the test-tube and animal experiments. Aside from the susceptibility of the respective bacterium, the action depends largely on the concentration of the drug and on the size of the inoculum. With a small number of bacteria, even bactericidal action is frequently obtained. It seems reasonable to assume (and this has been borne out in experimental work in animals) that few bacteria are easily controlled by concentrations which do not affect large numbers.

It is for this reason that we recommend the prophylactic use of these drugs in conditions where contamination of otherwise sterile tissues has occurred, or where pathogenic organisms are likely to develop their deleterious action.

LOCAL USE

This leads to the local use of the sulfonamide drugs. The same considerations are valid here as have been outlined in the preceding paragraph. The difference is that, with local application, we may obtain tremendous concentrations. We are confronted here with an entirely new phenomenon. While in the past germicidal drugs invariably damaged the tissue cells of the host, at least to some degree we have in the sulfonamides drugs which interfere, in some obscure manner, with the metabolism of some bacteria, preventing their multiplication, but which at the same time do not harm the tissue cells. This fact has been demonstrated again and again in tissue cultures, in animals, and in many clinical instances where healing per primam has been demonstrated quite frequently after the introduction of sulfanilamide crystals. The small number of bacteria is easily disposed of, and the drug is eliminated without giving rise to toxic reactions.

GENERAL PRINCIPLES OF MEDICATION

In case it has been decided that one of the drugs should be used, we suggest to start with high doses, to be decreased corresponding to clinical improvement, and continued for a short while after clinical recovery from infection. Severe toxic reactions do not occur in the beginning of medication more frequently with high than with small doses. On the other hand, sensitivity is frequently acquired, so that, after a prolonged use of small ineffectual amounts, it might not be possible any more to give later the desired large doses. The fluid intake should be regulated, so that a minimum of 1,000 cubic centimeters of urine excretion per day is obtained. Excess of fluid will promptly lower the level of the drug in the blood and tissue fluids. Medical supervision, with control of blood and urine, is essential. If alarming toxic symptoms appear, the drug should be discontinued and fluids forced.

Oral administration of the drugs is preferable to any other; if not possible, intravenous, subcutaneous, intramuscular, and rectal use are to be considered.

The doses of the various drugs cannot be stated categorically. In the case of sulfanilamide, one gram (15 grains) for each twenty pounds of body weight may be given per day, divided into fractions given every four hours to obtain a relatively constant level of the drug in the tissues. Children excrete the drug more rapidly, require and tolerate up to double doses and more, computed per body weight.

The common dosage of sulfapyridine and sulfathiazole in severe conditions is one gram every four hours after an initial dose of two to four grams.

FUTURE PROSPECT

The development during the past five years has shown beyond doubt that we are only in the beginning of bacterial chemotherapy. New drugs are appearing constantly and are received with great attention and confidence, as, for instance, sulfadiazine and sulfaguanidine. They do not have to wait any more for bold pioneers, as in the past, but they are readily tested on large series in acknowledged institutions. On the other hand, the medical profession is ready to discard any of the older preparations as soon as advantages of the newer drugs over the older ones become apparent. It is more than likely that newer drugs will be found which are more potent, less toxic and, perhaps, more selective than those discussed.

450 Sutter.

SULFANILAMIDE GROUP OF DRUGS: USE IN DISEASES OF THE EAR, NOSE AND THROAT*

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THE hope of finding a drug or chemical substance that will relieve suffering and successfully combat disease is almost as ancient as the history of man. Equally ancient are the sporadic outbursts of the announcement that the answer has been found. In general, the hope that it is a cure-all persists for a time; and then after the initial wave of enthusiasm has reached a crest, the field of usefulness narrows down until a vanishing point is reached. There have been a few exceptions—mercury, quinin, salvarsan. The primitive witch doctor had a bag of tricks and charms. The early apothecaries made numerous infusions and combinations of organic and inorganic matter. The early chemists made, first, the more simple combinations and, later, purposely made complex combinations with the hope that some one of them would end the search for a drug or combination that would rid the host of the invader and, in so doing, not irreparably damage the host. The discovery of the elements, and ways and means of isolating the elements, was a great step forward. This permitted study of their individual characteristics, the preparation of exact compounds, and the study of the action of these compounds both *in vitro* and *in vivo* experiments. This marked the foundation of intelligent chemotherapy. Advances made during the late nineteenth and early twentieth centuries in ascertaining the etiologic factor in the various disease conditions have been of prime importance to the progress of chemotherapy.

RECENT STUDIES

The empirical use of drugs prior to this time on a pure trial-and-error basis resulted in only a few discoveries that have stood the test of time. The past three decades have shown great progress. Hopes have run very high on many occasions during this period. The waves of enthusiasm directed first one way and then the other by the respective proponents and opponents of the various discoveries, have been a severe trial and strain on the reasoning powers of the individual who tries to serve his patient best by keeping his feet on solid ground. It is essential that he first curb his enthusiasm, yet be sufficiently pliable so that he is not enrolled in the ranks of the chronic disbelievers. This last-mentioned group has contributed nothing. There is ample reason why one should proceed with care and caution in adopting new forms of therapy because, in spite of the advances made both in compounding drugs and in ascertaining the identity of the etiologic agents of the various infections, even our present state of chemotherapy is still primarily empirical. This is because our present knowledge of the exact mode of action of the drug is still most incomplete. When this knowledge is available, the subject of chemotherapy will be robbed of much of the mystery that is associated with therapy, while the whole subject will be on a more firm foundation. It is comforting and satisfying, from a practical standpoint, to realize that this or that drug will be effective, but the important questions of why and how the drugs work must be answered.

PRESENT ACCLAIM OF SULFA DRUGS

The present wave of popular acclaim revolves around a group known as the sulfonamides. The first member of this group to be presented was sulfanilamide. Experimental and clinical evidence was offered to show that it had saved the lives of several patients suffering with puerperal fever, streptococcus septicemia. The next member presented was sulfapyridine, first known as M and B 693, and then came sulfathiazole, sulfaguanidine, and, lastly, sulfadiazine. The first four mentioned were initially presented as specialists in their fields: sulfanilamide for the streptococcus, sulfapyridine for the pneumococcus, sulfathiazole for the staphylococcus, and sulfaguanidine for the dysentery group. The fifth one, sulfadiazine, is, at the time of writing, too new to enter into this discussion. There is now ample evidence to question the advisability of continuing to consider the first three mentioned drugs as being truly specific in their action on the various organisms. Later work has shown that there is a wide margin of overlap in their action. It should be of interest to know that the sulfonamide group is a large one. Already several hundreds of compounds have been made, and the possibilities for further expansion is almost unlimited. This immediately presents the fact that the value and limitations of this group could not possibly have been explored with any great degree of accuracy in the short period of time the compounds have been available for laboratory and clinical trial. Thus far, my experience has been limited to observations on the results obtained following therapy, with the first three members of the group—sulfanilamide, sulfapyridine, and sulfathiazole—and, therefore, further discussion at this time will be limited to these three drugs. The otolaryngologist should be especially interested in this group of drugs because they constitute a definite and formidable addition to our armentarium, since their action is directed against our familiar old enemies—the streptococcus, staphylococcus, and the pneumococcus.

INDICATIONS

The question as to when to prescribe one or the other of the drugs has not been settled except as regards the presence of complications. I feel that the wholesale prescribing of the drugs is definitely wrong and wholly unjustifiable. Any such practice is theoretically incorrect, clinically unsound, and constitutes a definite hazard to the welfare of the patient. The rapid transmission and wide dissemination of medical information to the public at large by means of the radio, newspapers, and popular magazines may at times present a definite problem. All too often, they accept the information that is presented without realizing that they are

* Read before the Section on Eye, Ear, Nose and Throat at the seventieth annual session of the California Medical Association, Del Monte, May 5-8, 1941.

not qualified to understand the facts presented, and, therefore, are not in a position to segregate false statements from the true. The public's reaction to the information about the sulfonamides is a natural one, and has resulted in its demands for this form of therapy in almost all forms of sickness. I may be entirely wrong in inferring that the drug has been prescribed unnecessarily, but it is possible that the trite popular statement, "If sulfanilamide does not cure your patient, you had better go over him thoroughly," is not without its point.

DANGERS

There is now sufficient available data to show that the administration of the members of this group of drugs is not entirely free of danger; yet, in spite of this information, it is amazing to learn of the number of individuals who have received relatively large doses of the drug and have not even been confined to their dwellings, let alone hospitalized. A condition that is equally deplorable, and far more common, exists in the large number of individuals who have received inadequate and ineffectual amounts of the drug. The use of the words "inadequate" and "ineffectual" assumes that in these instances there were sufficient indications to warrant the institution of drug therapy. The excuse, that it could not do the patient any harm, is not only untrue but valueless. That it did not do the patient any harm is fortunate, but does not let down the bars for universal therapy. If the patient is in need of psychotherapy, the substitution of a less potent pill is advisable, unless one is able to cope with the situation in a more intelligent manner. It should be evident by now that it is not good judgment to recommend the administration of the drug to every patient who has an acute upper respiratory infection. Our knowledge from the past shows that at least 95 per cent of these infections subside without complications of any sort. The present literature presents the results of controlled work in the field of chemotherapy by investigators qualified to do such work. These results show very little conclusive evidence that the incidence of complications of the upper respiratory infections is lessened by the early administration of members of this group of drugs.

COMMENT

It would appear from the foregoing that there is little use in having discovered the sulfonamides, in the first place, or of recommending their use as therapeutic agents in the second place. Such is not the case. The sulfonamides, as we know them, are a great contribution and, when properly used, have saved many lives; and when understood more thoroughly, will save a still greater percentage. This brings us to the point of deciding when they should be used. The answer is two main conditions. First, in those instances wherein the initial infection is overwhelming and the resistance of the host is definitely less than the virulence of the invader. Second, in those conditions where the infection breaks through the barriers set up by the host and invades either the blood stream or cerebrospinal fluid or both. The action of the drug is the same in both instances in that sterilization of the circulating fluids is accomplished rapidly and the host is aided in localizing the infection and keeping it localized. When this is accomplished, surgical removal or drainage of the localized area is essential, in most instances, to effect a complete cure. This last statement is subject to some reservation in that if localization occurs in certain areas that are well supplied by circulating fluid, and the area be of relatively small size, surgery may not be necessary. The original use of sulfanilamide in the septicemias following normal or induced labor is a good example. There the initial infection is overwhelming, and as soon as the septicemia is controlled the host is able to handle the infection of the pelvic organs. The septicemias resulting from an acute nasopharyngitis or tonsillitis is another example. In certain instances, surgery and institution of drug therapy have to be introduced concurrently. The treatment of septicemia and meningitis of otitic origin demands this combined form of therapy and in general does not respond to one without the other.

THERAPEUTICAL USE

The exact dosage of the sulfonamides does not follow any rule-of-thumb that can be applied to all patients. There are certain general principles that should be followed, because experience has shown that they give results. It is the general consensus of opinion that when therapy is indicated the blood-titer level should be raised to effective concentrations as soon as possible. There is considerable variation between the members of the group in their water-soluble factor and in their rates of absorption and elimination. These factors play an important rôle. In order to obtain a satisfactory concentration in the blood stream, the initial doses are usually relatively large. Due to the rapid elimination of the drug, it is necessary that the total daily dose be given in divided amounts, at three- or four-hour intervals, in order that the concentration in the blood stream be kept at a somewhat constant level. Hospitalization of the patient who is to receive therapy is quite essential if the therapy is to be conducted in an intelligent manner. The most effective means of determining the amount of drug necessary to maintain a satisfactory blood concentration is a daily titration of the blood. Daily blood counts and hemoglobin determinations should be routine during the early stages of therapy in order that the early stages of toxic reactions, in the form of neutropenia, leukopenia, and acute hemolytic anemia, be detected before irreparable damage be done. Daily examination of the urine is also essential, in that there is a possibility of kidney damage by the actual mechanical action of the crystallized acetylated form of the drug. Therapy must be continued for a sufficient period of time to allow the defense mechanism of the body to eliminate the invaders. If therapy is discontinued too soon, a recurrence of the disease is not only possible, but is probable, and a second attempt at chemotherapy will be necessary. The possibility of "drug fastness" of the organism and hyperactivity to the drug by the patient are not uncommon occurrences, and establish the fact that

this second course of therapy is being instituted under less favorable circumstances.

TOXIC REACTIONS

Chemotherapy with the sulfonamides cannot be maintained in certain individuals, owing to their response to the drug. The toxic reactions may be divided into two main groups in relation to their importance. The first group is composed of cyanosis, dizziness, headache, mental depression, malaise, and nausea. These reactions are not grounds for stopping therapy, and usually respond to either giving smaller doses more frequently, slight diminution in the total daily maintenance dose or sometimes skipping a dose or two. Vomiting of any marked degree necessitates routes of administration other than the oral one, because the dosage cannot be controlled and there is loss of fluids. The second group, comprising such reactions as acute hemolytic anemia, neutropenia, drug-rashes and fever, anuria, hematuria, toxic hepatitis and toxic psychosis, demand discontinuation of the drug. Sometimes an individual will respond unfavorably to one of the members of the group and be able to tolerate another. When the demand for the assistance afforded by this group of drugs is imperative, a shift to another is worth trying, but must be carried out with extreme care.

Certain of the actions of the sulfonamide group may offer themselves as factors that confuse or mask the clinical picture. The antipyretic action of the drug often produces a condition of false security. Likewise, the neutropenic action, when not too marked, allows weight to be added to the conclusion that the patient is progressing in a satisfactory manner. The analgesic action, or possibility of analgesic action, of this series of drugs has been afforded little or no mention in the literature to date. Clinical observations do support, in many instances, the contention that they possess an analgesic action. This action is not as marked as is found in the well-known, closely allied compounds of antipyrine and amidopyrine (phenazone and pyramidon), but it has been encountered too often to allow one to believe that the raising of the threshold for pain is a mere accident. Discussion of the possibility and probability of this action with the pharmacologists has resulted in the inconclusive answers that there is no reason to disbelieve the clinical findings, and that there are reasons to believe that some degree of analgesic action might be expected when one studies the similarities of the chemical structures of drugs. Drug fever is another not uncommon condition that may be expected to occur at any time after the first four days, or so, of intensive therapy. These reactions have been a definite source of confusion in certain instances.

SUMMARY

The idea of compiling a list of the diseases of the upper respiratory tract and arranging them into a table that would give information on the advisability of chemotherapy, dosage, duration of therapy and such, is intriguing, but at present quite useless. The present status of chemotherapy is not sufficiently advanced to permit this. A short summary of the general consensus of opinion will be of interest. Most favorable results have been obtained in controlling the septicemias. Meningitis of otitic origin has responded to the combination of drug therapy and surgical intervention for the removal and drainage of the mastoid area. Laryngotracheobronchitis has responded satisfactorily when therapy was started early in the course of the disease. Osteomyelitis of the skull has been favorably influenced by chemotherapy in conjunction with surgical removal of the infected areas and maintenance of drainage. The more chronic conditions demand a prolonged course of therapy. A small series of individuals with chronic serous otitis responded in a most satisfactory manner. Data on the advantages of chemotherapy for the acute cold, uncomplicated acute sore throat and acute otitis media are inconclusive. Neither the acute nor chronic stage of sinusitis is influenced favorably by the drug. A report on a series of treated and untreated peritonsillar abscesses showed no benefits from the drug therapy, and, strangely enough, there were more serious complications in the treated group than in the untreated patients.

LOCAL USE

One should not conclude a discussion of this group of sulfanilamides without at least mentioning that good results have been reported from the local application of the dry, powdered form of the drug on and into clean and infected surgical wound cavities. In the first instance, it is applied in an endeavor to prevent secondary infection. In the second instance, it is applied with the idea of having an adequate amount of the drug on the battlefield. My personal experience with this form of therapy has been so limited that any views I have on the subject are the results obtained from honest attempts to read and digest the literature on this phase of therapy. Apparently, no ill effects have been produced by this mode of application, and it is possible that the application of high concentrations of the drug where it is most needed, and with no loss of time, may be beneficial in certain conditions.

CONCLUSIONS

1. The group of sulfanilamides is a definite addition to our list of useful drugs, and intelligent administration of the members of this group has already saved many lives.

2. The wholesale administration of members of this group to patients suspected of having an infection caused by a susceptible coccus should not be tolerated. Such practice is detrimental to the patient, the integrity of the prescriber, and the future evaluation of the drug.

3. The administration of inadequate amounts of the drug may result in the production of a "drug fast" strain of the organism without a diminution in the virulence of the organism.

4. The administration of the drugs is not without danger.

5. Although there are certain properties of each member of this series that make one or the other

more desirable in a particular type of infection, true specificity of action is not present.

6. The possibility of toxic reaction to the drug, and the necessity for obtaining and maintaining an effective blood-level titer, make the hospitalization of the patient not only desirable, but almost imperative. The onset of early signs of toxicity will be noticed and the necessary laboratory facilities are at hand.

7. The "masking action" of the drug, in the form of leukopenia, neutropenia, antipyretic action and drug fever, may confuse the clinical picture.

490 Post Street.

EXTRAHEPATIC DUCT STONES: INDICATIONS AND PROBLEMS RELATIVE TO THEIR SURGICAL CARE*

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INTRODUCTORY.—Ten years ago, Crump[1] reported his findings after carefully performing one thousand autopsies where 77.9 per cent were over forty years of age. Three hundred and twenty-five, or approximately one-third, had gall-stones of various types. Seventy-eight, or 24 per cent of these three hundred and twenty-five, or 7.8 per cent of the thousand cases, harbored stones in the ducts. There were five instances of stones found in the common duct after previous cholecystectomy for gall-stones. Hence, every fourth patient with gall-stones had, in addition, stones in the bile ducts. Five years ago, Lahey[2] reported that he explored at that time the bile ducts in 44 per cent of his cholelithiasis operations and found stones in the ducts in 18.9 per cent of these patients; whereas, ten years previously he explored only 15 per cent and found stones in only 8.4 per cent of his cases. Clute[3] has reported a noted increase from 8.4 to 17.9 per cent of common-duct findings, with increase in exploration of the common duct. Evidently, for years, and in good hands, many patients have left the hospitals with unfound extrahepatic duct stones. This is still going on despite the fact that we have at the present time more safeguards and better-trained surgeons to examine diligently the bile ducts for pathology. It is most surprising, therefore, to know that many operators who feel capable and do a great deal of gall-bladder surgery have never opened or explored a common duct.

Any surgeon who has been in the position to do a great deal of gall-bladder and extrahepatic-duct surgery knows, by training, study, and experience, the many important difficulties and dangers involved in this problem. The careful and true appraisal of the patient very often taxes the ingenuity of the finest trained expert before he dares to subject his patient to a surgical procedure. He must, by analyses, determine whether the pathology is confined to the gall-bladder only, or possibly has also involved the ducts, because he knows that disease of the ducts is usually a sequel of severe disease of the gall-bladder.* If an old-fashioned cholecystostomy is done, or even the removal of an acute gall-bladder, he cannot justify an exploration of the extrahepatic ducts, because of the danger involved. Such extensive operative procedures carry a rather high mortality, unless the diagnosis is accurate, the patient properly prepared, and the procedure carefully planned and executed.

Graham and Cole,[4] in 1924, gave a cholecystography to the medical profession. Intensive study and perfection have made this a most important laboratory test, and we use it so much that we occasionally disregard prominent clinical signs of gall-tract disease and rely wholly on a cholecystogram, which fails to show gross pathology. The extrahepatic ducts, however, unfortunately, are not portrayed except in rare instances where the common duct has become a gall-bladder by size and function, following cholecystectomy. Administration of gall-bladder dyes may in such instances show stones in the common duct. It was not until Mirizzi,[5] in 1929, related his experiences with visualizing the biliary tract at operation in ninety-one cases that this important phase of study was brought to our attention. Later Best and Hicken,[6] in 1934, presented their studies of "Immediate Choleangiograms" at the time of operation, and "Delayed Choleangiograms," taken during the postoperative convalescence. This has stimulated much thought, and its use will be a very valuable observation in bile-duct surgery. We have made delayed choleangiograms in all our "T" tube drainage patients and found most valuable information. Immediate choleangiograms will, in time, be used to help us to visualize pathology within the ducts and to open only those involved and thus spare many patients the expense and danger attached to surgery of the extrahepatic ducts.

OTHER STUDIES

Another important advance in the care of biliary-duct disease has been the discovery that dilation of the sphincter by nitrites, atropin and magnesium sulphate, and the added use of bile salts, such as cholegogues as shown by Best,[7] stimulate the liver to increase bile secretion and mechanically flush the ducts. By this procedure small stones, blood-clots, mucous plugs, and débris can be from time to time washed through the ampulla into the duodenum. Such biliary flushes given to all post-operative gall-tract patients for extended time has lessened for Best and his coworkers the number of postcholecystectomy and cholecystostomy distress so often seen. We have used this procedure many times and have found it most useful for flushing the extrahepatic ducts. We feel certain that small stones inhabiting the liver radicles of the hepatic ducts migrate down to the common duct postoperatively. These and other foreign bodies can be flushed in like manner from the duct through the ampulla. There are also those selected old, weak and debilitated patients with small common-duct stones and débris, who can be treated by repeated biliary-duct flushings from time to time and perhaps spared the danger of surgical operation.

* Read before the Section on Surgery at the seventieth annual session of the California Medical Association, Del Monte, May 5-8, 1941.

* See Fig. 1.

The hemorrhagic tendency of the jaundiced patient to bleed excessively has always been a source of great danger. We have known that blood transfusions have assisted a great deal to check this tendency. We know now that these patients were deficient in prothrombin, evidently made in the liver, and that a volume of new blood temporarily added this element to the patient's vascular system. The administration of vitamin K with bile salts has become an important factor to insure a rapid and adequate prothrombin supply. This has rendered these jaundiced patients quite safe from the excessive and dangerous bleeding tendency. Postoperatively, vitamin K and bile salts must be continued to keep definitely the prothrombin level within safe limits.

Hypoproteinemia, or deficiency of globulins and albumin in the blood plasma due to liver injury, has recently been found to be an important factor mitigating against safe surgical procedures in these patients. With a sufficient amount of cellular elements in the blood stream, but with a deficiency of plasma proteins, the simple intravenous administration of blood plasma quickly and safely protects the patient from the hazards incident to inadequate blood proteins.

The problem of anesthesia to be given to these quite sick patients with a good deal of surgical risk must receive very serious consideration. Recent rapid strides in the science of anesthesia play no small part in the safety of extrahepatic duct operations. We have found, to our amazement, how easily and safely a common-duct operation can be done under local novocain anesthesia combined with barbital, avertin or scopolamin. Old people with accompanying dangerous conditions in other organs, such as coronary disease, excessively high blood pressure, or Bright's disease, in our experience have had a much easier and less complicated convalescence with local anesthesia than with ether, gas, or spinal anesthesia. Such pulmonary complications as atelectasis, bronchitis, and pneumonia can be greatly minimized by the use of analgesia with local novocain infiltration.

We must finally emphasize the importance of the surgeon well equipped with knowledge of the experiences of other good surgeons, along with a safe technique and good surgical judgment to apply these and other important preoperative and operative maneuvers for the safe conduct of the very ill patient through a hazardous surgical experience. A good surgeon endeavors to prevent the milking of gall-stones into the ducts while removing the gall-bladder after the ducts have been explored and a "T" tube anchored by sutures. Even in well-trained hands, I wonder if this does not happen quite often.

Exploration of the common bile duct and accessory ducts is not considered complete unless the ducts themselves and the papilla of Vater are proved to be normally patent. This is done by instrumental dilitation, most of us using curved forceps or a scoop or other available handy instruments. J. Bakes [8] devised dilators, and in 1928 described his results. These Bakes dilators are now universally used, and seem a safe and logical procedure in common-duct exploration. Scarring and stricture of the ampullary sphincter are easily produced by excessive dilation, hence cautious use of these dilators is necessary. Lahey,[2] however, warns us of danger by reciting two instances of reflux from the duodenum and death in each instance from an anaerobic infection. Zollinger et al. [9] take an opposite view from the result of an experiment with sixty-three dogs. They summarize by saying that after dilation of the ampulla the common duct fills with exudate and that the lumen returns to its original size, regardless of the extent to which it was dilated at operation.

Exploration of the common and hepatic ducts at the primary surgical procedure is justified and most important when the usual signs of pathology exist and when pertinent symptoms and findings justify the procedure. It may be well to enumerate these most important signs and findings.

IMPORTANT SIGNS AND FINDINGS

1. *Jaundice.*—Jaundice due to biliary-duct obstruction is a symptom for surgical interference. If present at the time of operation, such important data as intermittency, chills and fever, length of time present and general conditions of the patient are important. The history of past episodes of jaundice lead to favorable opinions relative to the presence of a foreign-body obstruction. New growths situated in the ducts, at the papilla, or in the head of the pancreas, whether with or without stones, have their definite place in the diagnostic repertoire of jaundiced patients. The body tissues must be drained of bile, either by the removal of the obstruction or by the establishing of a detour of the bile stream through the gall-bladder into the gastro-intestinal tract. For this reason it seems best to explore the ducts before removal of the gall-bladder, should this vesicle become necessary for an anastomosis.

Often a mass cannot be differentiated between a stone or a new growth. A cambric needle may be very useful in this situation. A gritty feel usually indicates a stone. The needle can be forced through a new growth with a characteristic sense of some resistance.

Postoperative cholemia, followed by anuria, is a matter of grave concern in these jaundiced patients. It may be transient, but it is often fatal. The serum bilirubin, blood urea nitrogen, and nonprotein values are all elevated. The CO_2 combining power of the blood and the blood chlorid are decreased. The excretory and detoxifying power of the liver being impaired, throws the waste products upon the kidneys, with consequent renal failure. One such patient recently showed at autopsy a most marked edema of the parenchyma of both kidneys. Every known means, including cystoscopy, were used to relieve this patient.

2. *Palpable Stones.*—Palpable stones within the ducts are a very frequent experience. However, the casual thumb-and-finger palpation is unreliable, for it may fail to reveal real gross pathology, since stones can easily slip to and fro in a most elusive manner. The retro- and intramural duodenal por-

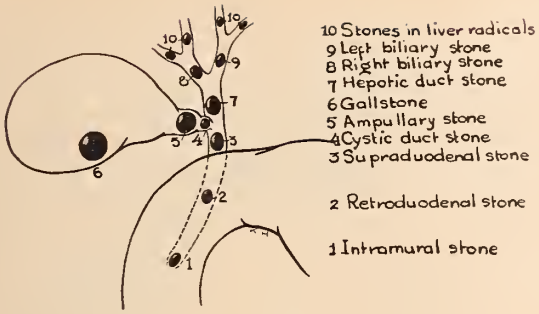

Fig. 1

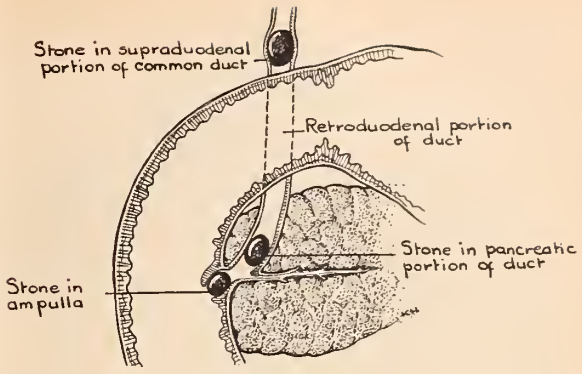

Fig. 2

Fig. 1.—Graphic portrayal of the various positions in which a calculus may be found in the biliary apparatus.
Fig. 2.—Figure represents the common duct and the usual location of a calculus therein. Those calculi found in the duct covered by the duodenum offer the most difficulty in surgical removal.

tion of the common duct may not usually be satisfactorily palpated, because of the position of the duodenum and the consistency of an enlarged pancreas encircling the common duct. Often the duodenum must be separated from its attachments, raised and retracted so the distal and intramural portion of the common duct can be easily palpated and at times incised. A large impacted stone at the ampulla is more safely removed by the transduodenal route (Fig. 2). Contrast media or air injected into the common duct at operation and x-rayed with the abdomen open may assist in determining the presence of stones (Fig. 3). It will also, in many instances, reveal that choledochotomy is unnecessary, thereby relieving the surgeon of anxiety relative to stones left behind.

3. *Previous Gall-Bladder or Common-Duct Operations.*—Previous gall-bladder or common-duct operations where symptoms recur are among the common causes for a common-duct exploration, because stones have either been missed at the primary operation or have migrated from the liver ducts. Stricture of the ducts or ampulla, due to injury at a former operation or a spasm interfering with common-duct drainage, is seen in many instances (Fig. 4). Removal of the acute swollen, frozen-in, necrotic gall-bladder leads to many injuries of the ducts. We have found that partial removal of the viscus, with curettage or cautery of the remaining mucosa, spares much anxiety regarding ductal injury. An immediate choledochogram made at operation may be of inestimable value to identify the character and location of the obstruction before an incision into the duct is made (Fig. 5). Before removing the "T" tube a choledochogram may be very useful for information concerning overlooked foreign bodies and malformations. We do not see many delayed secondary duct operations, since choledochograms are carefully made, and since surgeons acquire greater skill and exercise more care in opening and probing biliary ducts.

4. *Biliary Colic.*—Biliary colic, associated with chills and fever, indicates that here is present infected bile and an interference with drainage. A careful exploration of the interior of the ducts to remove stones and débris and, in addition, dilate the sphincter, is advisable. The release of pressure of infected bile from the liver parenchyma assists the patient to a more rapid recovery. The use of sulfamides probably can play a very important rôle in the therapy of this dangerous condition.

5. *Frequent Attacks of Biliary Colics.*—Frequent attacks of biliary colics where small and

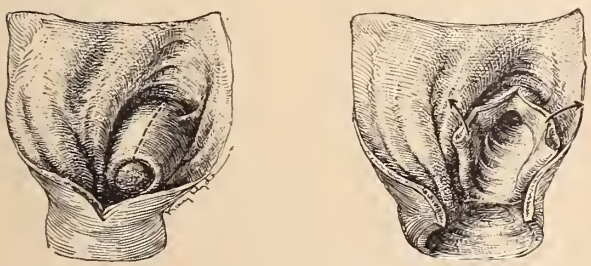

Fig. 3.—Transduodenal section of ampulla and extraction of an impacted stone.

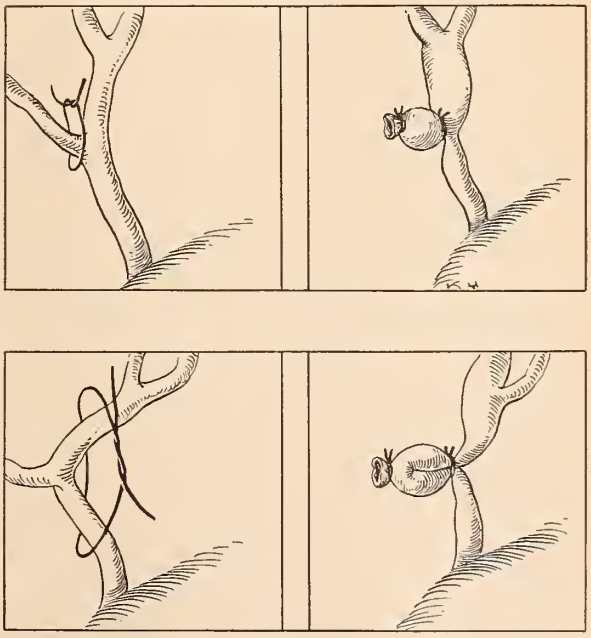

Fig. 4.—Faulty methods of ligation of the cystic duct.

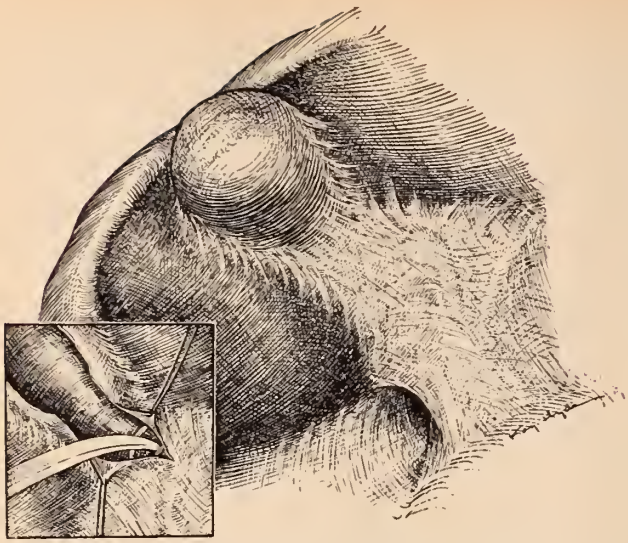

Fig. 5.—Use of cautery or curette to destroy mucosa remaining in base of "frozen in" or necrotic gall-bladder.

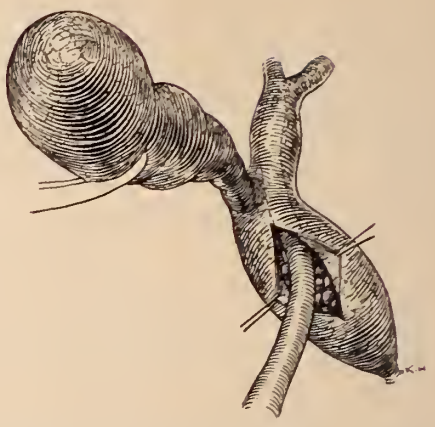

Fig. 6.—Use of catheter in washing out debris and stones from common duct. (Good exposure without traction enables the cystic duct to be accurately ligated. A tight ligature may sever the duct. Faulty ligation causes many common duct injuries.)

medium-sized stones are found in the gall-bladder may be a sign of many small stones having passed through the dilated cystic duct into the ductal system. Conglomerations of cemented small stones and sand easily occur in the ducts. Removal of the stones from the ducts is, of course, mandatory. Dilatation of the papilla may serve to enlarge the exit to permit overlooked stones to pass readily.

6. *Frequent Transient and Not Severe Attacks of Biliary Colics.*— Frequent transient and not severe attacks of biliary colics are usually associated with many small stones and sand being passed daily or at very frequent intervals from the gall-bladder. One recent patient had over eleven hundred barley-grain-sized stones in the gall-bladder and two hundred such in the common duct. In such instances, one would suspect that the liver radicles contain many such small stones and continually feed the extrahepatic ducts. Irrigations of all the ducts with normal saline and a catheter will be most useful in removing all such stones except those from the deeper radicles within the liver (Fig. 6). However, one large stone, or a conglomeration of such stones, often lodge at the ampulla and greatly interfere with the postoperative convalescence of the patient, unless the common and hepatic ducts are thoroughly explored and cleared of all débris. The stump of the cystic duct is not a safe place to leave stones either, for these may form the nuclei of much larger common-duct stones. Biliary duct flushes at frequent intervals are a very important therapeutic consideration in such instances.

7. *Dilated Common Duct.*—A dilated common duct must be recognized and carefully appraised. It is usually due to an obstruction in the duct itself, or in the head of the pancreas or the ampulla of Vater. Puestow and Morrison,[10] in 527 routine autopsies devoid of biliary disease, found the average circumference of the common duct to be about 12 centimeters, or about the size of a goose quill. Routine exploration of such ducts prolongs the operation, adds some danger and may increase the frequency of strictures. The noncalculus dilated common duct often encountered is one that has replaced a functionless gall-bladder. When infection is present, bile sand and calcium bilirubinate stones are formed. Cholecystectomy does not break the chain of events, and recurrent distress often ensues. The biliary flush, as described by Best,[7] has been found very useful in these patients. All such dilated ducts should have the bile sampled by needle and syringe and inspected before being opened and thoroughly explored. The bile concentration is noted. It may be laden with flecks of débris, crystals, blood cells and other foreign matter, and indicates a disturbance that must be found. Clean yellow bile samples will often give the clue that no foreign bodies will be found and that attention must be focused more on the function of the ampulla to drain off bile and unfound stones or perform, in a few selected instances, a choledochoduodenostomy.

8. *Biliary Colic with a Gall-Bladder Without Stones.*—Biliary colic with a gall-bladder without stones may present a really difficult problem. In the past, too many such gall-bladders were removed. They were called strawberry gall-bladders, and there was not enough attention given to exploring the extrahepatic ducts. These are the patients that have probably given us the most instances of post-cholecystectomy distress syndromes because of overlooked intraductal pathology. The surgeon must satisfy himself that the ducts are patent, and the ampulla by dilation is adequate to drain the common duct properly. Recurring transient edema of the pancreas can give the same picture. Serum amylase studies may be most advantageous in the routine study toward a correct diagnosis.

9. *Contracted Gall-Bladder.*—Contracted gall-bladder results from a long-standing biliary inflammation or an old empyema of the gall-bladder. These gall-bladders become functionless and cease giving symptoms. However, with a history of distress and the finding of contracted gall-bladder common duct, pathology is usually present and must be removed. Here again dilation of the ampulla may be necessary to drain off any elusive stones which may be missed despite a careful exploration of the ducts.

10. *Thickened Head of Pancreas.*—Thickened head of the pancreas can be due to an inflammation secondary to infection in the biliary tract. How extensive this thickening is, and to what degree obstruction of the common duct is due to this factor, must be determined by the surgeon. It may be most difficult to examine the intramural or the portion of the common duct encircled by the enlarged pancreas. Often one may find an impacted stone at the ampulla in the presence of a thickened pancreas. Dilatation of the ampulla, if possible, seems most important in this condition also. It may be impossible to differentiate between malignancy and chronic inflammations in the head of the pancreas. Elevating the duodenum for better exposure and biopsy may tell the true story.

11. *Cholangitis.*—Cholangitis often continues or recurs, due to an inflammation and an inadequate drainage of the biliary tract through the ampulla. In selected patients it is often advantageous to open the common duct, dilate the ampulla with dilators, and drain for a considerable time the biliary ducts. Sulfamide therapy here again may prove to be most important in these instances.

12. *Impaired Liver Function.*— Impaired liver function with marked dye retention and subnormal bile drainage may result from liver damage due to pressure incident to poor drainage through the ampulla over varying lengths of time. Extrahepatic duct exploration and the occasional findings of impacted stones in the ampulla are most gratifying. Besides inspection of the ampulla, dilation may be necessary to increase drainage of the common duct.

13. *Contracted Common Duct.*—Contracted common duct is a most unusual picture and found at operation only. In such an instance, one may be quite certain that an overlooked obstruction in the hepatic duct is present. A long-standing jaundice is also part of the picture. Removal of the stone or obstruction with adequate drainage seems the proper treatment. One such patient with complete jaundice for one year following cholecystectomy revealed a common duct so contracted that it was difficult to identify. Puncture of the hepatic vein occurred. A choice for repair had to be made between a suture or ligature or pinch clamp. A curved clamp efficiently held the rent and on the fifth day the instrument was removed, with a most successful vascular repair. The common duct, after the removal of this large stone from the right hepatic duct which had by this position closed

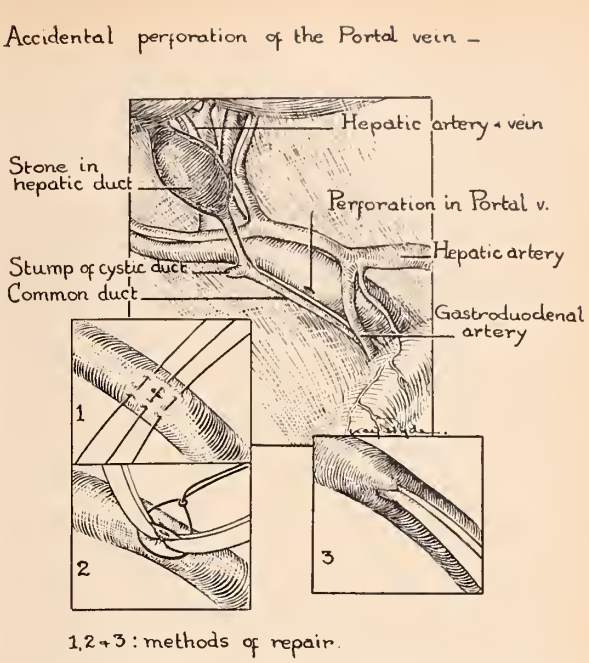

Fig. 7.—I found that closure of the portal vein rent with a curved forceps and allowed to remain for five days was a very successful method in one such instance.—E. E. L.

both hepatic ducts, fully recovered after a few weeks' drainage and without any fistula formation (Fig 7).

EXPLORATION OF BILE DUCTS

A simple and safe method of exploration of the bile ducts must be developed by any surgeon who performs gall-bladder surgery. This must be done without increase in mortality nor damage to the ducts. After viewing the gross features presented in the field to be explored, and after sponge packs have been placed to absorb any spillage into the region of the foramen of Winslow, the common duct is needled and a syringe specimen of bile is taken for gross analysis. This test helps to identify the duct itself and allows for an inspection of the character of the bile. Heavy crystals, mucous shreds, and débris may cloud the specimen. This rather simple test may help to decide for or against exploration of the ducts. The surgeon finds it advantageous to open and explore the ducts from the left side of the patient because of the natural ease with which he can handle the structures. The duct is secured by long silk sutures and then opened longitudinally, unless for some reason it is suspected that a cholecystoduodenostomy may be necessary, in which instance the incision is made across the duct. The stones are carefully removed with scoops and forceps until the biliary, hepatic and common duct seem free of stones and débris. The papilla of Vater is then gently probed and then gradually dilated, preferably by Bakes' dilators. This may eliminate a protracted "T" tube drainage to the outside. The papilla should be dilated from 7 to 10 millimeters. This will allow good common-duct drainage. It may sometime become necessary to open the duodenum for retrograde dilation with urethral sounds, which we have done on rare occasions. The ducts are then irrigated in all di-

TABLE 1.—*Review of Six Months' Surgery of the Biliary Ducts, Los Angeles General Hospital*

Gall-bladder operations	72
Common duct explorations	23
Stones found	18
Stones not found	5
Deaths	4 (17.4%)
One cancer pancreas	
One acute pancreatitis	
One enlarged pancreas	
One explored—no stones (pneumonia)	
Indications for exploratory of ducts	
Dilated ducts	18
Stones felt	11
Jaundice	9
Choleangiography	
"Immediate"	0
Postoperative—Normal	12
Not made	12
Not made—Deaths	4
Stenosis C. D.	1
Stenosis at ampulla	1

rections with normal salt solution. After the ducts seem clear, a small "T" tube with short arms is then sutured into the duct and led to the outside along with a Penrose drain through a stab incision below the twelfth rib. The Penrose drain is placed in Morrison's pouch, where all drainage collects. The patient is placed on the right side to facilitate dependent drainage as much as possible.

We have, in several instances, closed the common duct tightly at the primary choledocotomy. Of course, any overlooked stone, or edema of the duct or papilla causing intraductal pressure, may cause rupture of the ductal suture line and bile peritonitis. This hazard we shall avoid by discontinuing this practice, because we feel that convalescence may be markedly retarded, due to an inadequate bile drainage. The "T" tube drains one-half to one pint of bile daily and serves to give some indications of liver activity and, in rare instances, gives valuable information concerning the patency of the duct outlet. It also serves a very valuable function in postoperative choledochographic visualization of the duct system. The tube is removed on the twelfth day, as a rule, and the stab wound is usually dry in three or four days. In no instance have we had reason to regret tube drainage of the common duct.

BILIARY-DUCT SURGERY AT LOS ANGELES COUNTY GENERAL HOSPITAL

I have recently reviewed the biliary-duct surgery performed at the Los Angeles General Hospital for the last six months of 1940. I found there were seventy-two gall-bladder operations, with twenty-three common-duct explorations. Eight of these were secondary operations for common-duct stones, either not found or purposely left at the primary operation. Two of these were instances where empyema gall-bladders were drained only, leaving the bile ducts unexplored (Table 1). There were two aged patients in whom the gall-bladders were not disturbed after removing large common-duct calculi. Calculi were found in eighteen patients, and none were found in five. The indications for exploration were perhaps present, and either the stones were missed or some other such factor, such as biliary dyskenesia, was present in these five noncalculous reported duct cases.

There were four deaths, or a mortality of 17.4 per cent. Analysis of the records of these deaths reveals only one perhaps avoidable instance, whereas the others pertained to disease of the pancreas.

The gross indications for ductal exploration were interesting in that eighteen were opened because of a dilated common duct. Stones could be felt in eleven of the eighteen, which is a rather surprising observation. As previously stated, stones are elusive, and palpation alone cannot be relied upon as a safe indication for intraductal exploration.

Jaundice was present or quite recent in nine instances. The blood chemistry reports, such as icterus index, cholesterol and esters, although important, are not included in this survey.

No instance of "immediate" choleangiography is included in these records. In the near future, facilities for this important observation must be made at all large institutions. "Delayed" choleangiograms were made in fourteen instances only, and of this number there were observed two instances of inadequate drainage of the biliary-duct system, due either to injury of the ducts or edema or stricture at the papilla. Choleangiography has a definite place in the proper surgical management of biliary-tract disease.

CONCLUSIONS

1. Bile-duct disease is usually due to extension from the liver or gall-bladder.
2. Ductal stones are found in 25 per cent of patients with gall-stones.
3. With some exceptions, all stones should be removed at a primary operation.
4. Definite indications for duct explorations exist and should be well known.
5. Each surgeon must develop his own procedure for duct exploration.
6. "Immediate" choleangiography has a definite place in these operations.
7. Delayed choleangiography is mandatory in all postoperative draining ducts.
8. The therapeutics of lowered prothrombin and blood proteins is important.
9. A plea for the use of local anesthesia in selected cases is made.

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PRIAPISM FROM HYPERNEPHROMA METASTASES IN THE CAVERNOUS BODIES*

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IT is not my purpose to present a discussion of priapism. The paper is chiefly inspired by an unusual case of enlargement of the penis due to metastatic carcinoma of the erectile tissue, with priapism a secondary factor. Indeed, as in most similar cases, the priapism was incomplete; for the enlargement of the penis, and engorgement of the venous spaces, was not accompanied by muscular contraction nor the erect position of the organ. The term "false priapism," used by Gadrat, seems somewhat more appropriate.

LITERATURE

Scheuer,[1] in 1911, and Hinman,[2] in 1914, published excellent articles on priapism, and each in his classification included local malignant disease as one of the causes. In his tabulation of 133 cases from the literature, Scheuer mentions one of primary angiosarcoma, or endothelioma, reported by Maurer [3] in 1883, and one of metastatic carcinoma of the cavernous bodies from a primary carcinoma of the bladder published by Neumann [4] in 1882. He also mentions that Weber had a patient with metastases to the erectile tissue from a tumor of the testicle; but his catalogue of the cases and reference to Weber's [5] original article fail to reveal the case, and I have found no other reference to it.

In his review of 170 cases of priapism collected from the literature, Hinman found thrombosis of the veins of the penis in 125, and says that the venous thrombosis in two of these was due to local newgrowths. A study of his bibliography reveals that these were the same cases cited by Scheuer. It is obvious, therefore, that neoplasm, either primary or metastatic, is not a common cause of priapism.

COMMENT

It is true that primary tumors of the penis may sometimes invade the erectile tissue diffusely, causing enlargement of the entire organ and even priapism. Young [6] has pointed out that carcinoma of the glans, though it usually extends along the lymphatic channels to the regional lymph glands, may occasionally infiltrate the cavernous bodies by direct extension. Likewise, cancer of the urethra has been found to produce a similar result. Allenbach,[7] in 1916, described such an occurrence, and Culver and Forster [8] had a patient in whom the whole shaft of the penis became an indurated mass, through invasion, however, of the corpus spongiosum.

Malignant tumors primary in the cavernous bodies usually belong to the sarcoma group. Joelson,[9] in 1924, collected 34 such cases, and Cecil,[10] writing in Cabot's Urology in 1936, brought the number to 47. Of these, 13 were endotheliomata, of which, according to Joelson, the majority spread diffusely through the cavernous bodies and produce some degree of priapism. Of the other types of sarcoma, the melanoma practically never, and the others only rarely, infiltrate widely, but remain as a localized rounded nodule. However, the case presented by Frontz and Alyea,[11] in 1927, apparently was a primary sarcoma of the erectile tissue, with extensive metastases, and associated with a definite priapism. The account, as published, is not clear as to the origin of the tumor, and it has been referred to by other writers as a primary sarcoma of the prostate with metastases, but study of the evidence seems rather to favor a primary tumor.

The patient whose history I am presenting belongs to the smaller group in which the enlargement of the penis was due to invasion of the corpora cavernosa by malignant cells from a distant primary focus.

REPORT OF CASE

Mr. L. H., a man of 72, was admitted to the hospital on September 15, 1938, with a hematuria of three weeks' duration, much more severe in the last 24 hours. There had been fleeting pain in the region of the left kidney, slight frequency of urination, but no difficulty, though he had passed a few small clots.

His past medical history was quite extensive, and included several operations. He had been discharged from the hospital only a month before, after an illness of several weeks, characterized by high fever and rather severe right abdominal pain, for which no exact diagnosis had been made. While in the hospital numerous urinalyses had been made, all of which had been normal.

The physical examination revealed a tall, undernourished, elderly white male. Temperature, pulse, and respirations were normal. Blood pressure was 110/70. Loose-fitting, artificial teeth showed the marked loss of weight from his chronic illness.' Heart and lungs indicated nothing of note. Abdomen revealed two operative scars, one with a large hernia. Both kidneys were palpable, the right easily so, as it was distinctly lower than normal. Neither kidney was tender nor nodular. Prostate was slightly enlarged and smooth. External genitalia at this time were entirely normal.

The blood count showed a moderate secondary anemia and a definite leukocytosis, with 24,000 white cells, of which 87 per cent were polymorphonuclears. Urine contained small clots, was distinctly red, and microscopically was loaded with erythrocytes and only a few leukocytes.

Cystoscopy was done the same day. The instrument passed easily and about one ounce of bloody urine was found in the bladder. A few small clots were aspirated. There was moderate prostatic obstruction, but no trabeculation of the bladder wall, and no tumors, stones, or foreign bodies. The urinary jets from the right ureteral orifice were clear, but those from the left side were distinctly bloody. The function of the right kidney was normal, while that of the left was reduced about one-half. The

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Chairman's address. Read before the Section on Urology at the seventieth annual session of the California Medical Association, Del Monte, May 5–8, 1941.

Fig. 1.—Autopsy specimen of the penis invaded with carcinoma, with normal control.

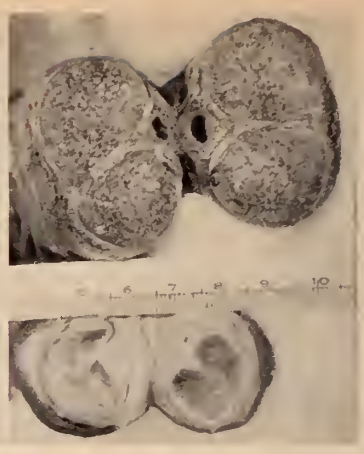

Fig. 2.—Cross section of the penis, showing invasion of the erectile tissue, with normal control.

urine obtained by ureteral catheter from the right side was normal, while that from the left was grossly bloody. B. coli were cultured from this kidney.

The pyelograms, made with Skiodan, showed the right kidney displaced downward, but the pelvic outline essentially normal. In the left kidney, the upper and middle calyces were distorted, and the diagnosis was made of a tumor of the upper pole of the left kidney. We felt that possibly the displacement of the right kidney might be due to external inflammatory disease, possibly an old perirenal infection, which would also account for his prolonged severe illness during the summer. The bleeding left kidney was lavaged with silver nitrate several times in an attempt to stop the bleeding.

A transfusion was given the next day, but the bleeding continued, so a left nephrectomy was done four days later. A large solid tumor was found, involving the upper pole, extending into the perirenal tissue and the pedicle, so that the nephrectomy was very difficult, and we did not feel that the tumor was completely removed. There was invasion of the renal vein and we encountered a good deal of bleeding. He was given one transfusion on the table and another later in the day.

The postoperative course was rather stormy, but there were no serious complications and he was able to leave the hospital on the nineteenth day. However, about ten days after the operation, approximately two weeks after the cystoscopy, while still in the hospital, he began to complain of tenderness and soreness in the penis. Examination revealed a diffuse swelling of the distal half of both cavernous bodies, without apparent involvement of the glans nor of the corpus spongiosum. From that time until his death, two months later, the penis gradually became larger and he continued to complain of tenderness and soreness, but never of any urinary difficulty. There were no nodules at any time, but the diffuse swelling increased and gradually included more of the organ. There was never an erect position, but the penis became about four times the normal size. The clinical diagnosis was made of thrombosis of the cavernous bodies, probably due to metastatic cancer.

Death occurred on November 28, 1938, from malignant cachexia and terminal bronchopneumonia. The autopsy was done by Dr. A. G. Foord, pathologist of the Huntington Hospital, Pasadena, who had also examined the operative specimen.

I have summarized the important findings of Doctor Foord's rather extensive descriptions.

The primary tumor involved nearly the entire upper pole of the left kidney, had invaded the renal vein, and had broken through into the perirenal tissue. It was only partially encapsulated, and had the typical gross yellowish appearance of a clear-cell adenocarcinoma, or so-called hypernephroma. The histology was typical of this tumor. There was a fairly well defined capsule, which was, however, extensively invaded. In the stroma of the capsule, and particularly growing in the blood vessels, including the renal vein, were solid nonvacuolated tumor cells, showing no evidence of foamy cytoplasm. Numerous veins were distended by nests of these cells with abundant solid staining cytoplasm and large hyperchromatic nuclei. There were a few nests of these cells throughout the tumor, but they were most abundant in the blood vessels and lymphatics of the tumor wall. It will be seen, therefore, that there were two distinct types of cells in the tumor, though Doctor Foord called it an adenocarcinoma, or hypernephroma.

The important autopsy findings were:

1. Local recurrence in the form of a mass involving the left adrenal and the pedicle of the kidney.

2. Microscopic metastases in the liver and lungs, without gross evidence of tumor in these organs.

3. Solitary metastases in the tail of the pancreas and in the substance of the right kidney.

4. A solid metastatic globular mass, about five inches in diameter, above the right kidney, attached retroperitoneally to the under surface of the liver. It completely surrounded and compressed the right adrenal, without invading it. This mass obviously was responsible for the low position of the kidney shown in the pyelogram.

5. A small encapsulated abscess lateral to the cecum in the lumbar gutter. This apparently was the cause of his prolonged illness and fever before we saw him, but no connection with the bowel or the appendix could be demonstrated.

6. The penis was profoundly enlarged, measuring in the embalmed state 23 centimeters from the apex of the prostate to the meatus, with an average diameter of 5 centimeters. The glans was not involved, but the distal 7 centimeters of the shaft was particularly large and firm, and the whole organ was in a state of erection. Multiple sections show marked enlargement of both corpora cavernosa, with distension of the cavernous spaces, some being 2 to 3 millimeters in diameter, with the lumen filled with grayish tan material, apparently tumor growth. At the base of the penis the corpus spongiosum was slightly invaded, but the urethral channel was fully 5 millimeters in diameter and not obstructed. The deep dorsal vein and several smaller tributaries were plugged with a gray-red thrombus, which extended upward into the periprostatic plexus. The left pudendal vein and the internal iliac vein were also thrombosed to the level of the junction with the external iliac vein.

The histology of the metastases showed two distinct features. The first was that, whereas the primary tumor was composed largely of the typical, large foam-cells characteristic of hypernephroma, with only groups of polyhedral solid staining cells especially about the periphery and in the lumen of the vessels, it was these latter cells which made up the greater part of the metastases and even the local recurrence. The large mass surrounding the right adrenal was made up of the typical foam-cells, but in the other metastases practically no cells of that type were found. The second feature was that everywhere the metastatic tumor cells seemed to select the lumen of the vessels, with relatively slight invasion of the stroma of the organ

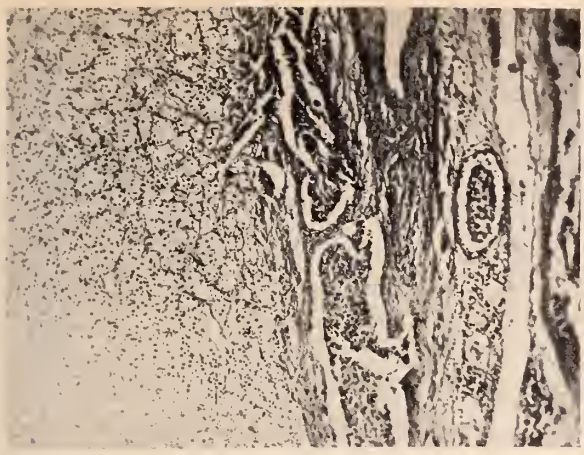

Fig. 3.—Section of the primary tumor, showing invasion of the venous spaces of the capsule with a different type of tumor cell from the typical hypernephroma.

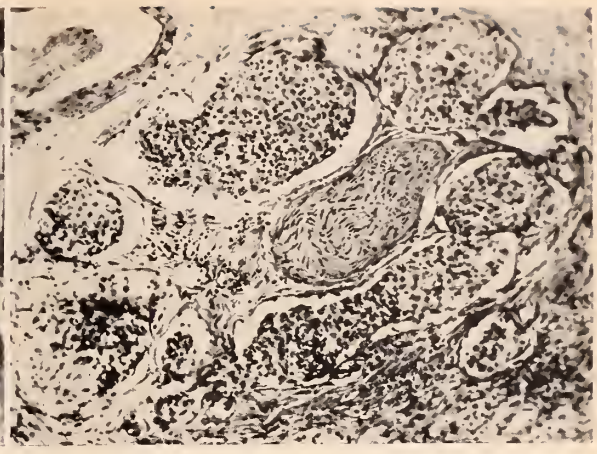

Fig. 4.—Microphotograph of the metastatic tumor of the cavernous bodies, showing tumor cells filling the venous spaces.

involved. This was especially noticeable in sections through the cavernous bodies, which showed marked distension of the venous channels, completely filled by tumor cells. Most of the growth was necrotic, but in the smaller channels viable tumor was seen, composed entirely of the solid type of cell, and without invading the stroma.

DISCUSSION

The rarity of this condition is shown by the fact that Begg,[12] in 1928, reported what is apparently the only similar case in the literature, a patient with metastatic hypernephroma in the cavernous bodies. His patient was a man of 62 who complained of a persistent priapism for five weeks. He had a greatly enlarged prostate by rectal examination. Cystoscopy being impossible, a suprapubic enucleation of the prostate was done, hoping to reduce the priapism. The patient died, and the autopsy revealed a large hypernephroma of the left kidney, entirely unsuspected during life. The corpora cavernosa were found densely infiltrated with typical masses of tumor, but the capsule was not involved. In this case, strangely enough, no other metastases were found in the body.

While preparing this paper, Dr. G. S. Sharp, consultant to the neoplastic clinic at the Veterans' Hospital at West Los Angeles, gave me the following incomplete account of a patient seen there last summer. This man, 45 years of age, had a right nephrectomy for tumor some five years ago. He did well for five years, then began to develop recently a constant priapism. General examination was negative, and x-rays of the chest showed no metastases. The penis was enlarged and erect, measuring 16 centimeters long, and 5 centimeters in diameter. There was one ulcerated nodule on the glans, about 1 centimeter in diameter. Of eight other definite nodules along the shaft, two were ulcerated. No biopsy was done, but a clinical diagnosis of metastatic carcinoma was made and x-ray therapy advised. The patient left the hospital and returned to his home in Salt Lake City, where I understand he is still alive.

The most common site of a primary malignancy from which metastases to the cavernous bodies occur is the prostate. I have succeeded in finding nine such cases. However, the prostate is an adjacent organ, and it must be realized that in any or all of these cases the involvement of the cavernous bodies may be by direct extension. Young says that carcinoma of the prostate often invades the walls of the membranous urethra, presumably through the lymphatics, and less often pushes on into the bulb. When this occurs, the erectile tissue is invaded, the sinuses being filled with tumor cells. At the base of the penis the process may break into the corpora cavernosa and eventually produce a carcinomatous priapism. The great numerical preponderance of these cases supports such a view.

OTHER REPORTS

Two of the primary tumors of the prostate were sarcomata. One, reported by Cowie,[13] was a boy of nine who had a priapism for several months. The autopsy by Warthin revealed an "oat-cell" myxosarcoma, primary in the region of the prostate, with extensive metastases in the cavernous bodies and elsewhere. The other sarcoma was found by Chauvin and Emperaire [14] in a boy of 20. He had an incomplete priapism from several metastatic nodules in the erectile tissue. X-ray therapy was used as palliative treatment. I have excluded the sarcoma described by Frantz and Alyea, though it has been referred to as of prostatic origin.

The seven examples of carcinoma of the prostate were reported by Toffier,[15] Nogues,[16] Guibal and Pavie,[17] Paglieri and Schiappapietra,[18] Young,[6] and Cecil.[19] Cecil has seen two cases, one of which he reported to me by personal communication. Young felt that his case can be explained as a direct extension, and this is possibly true of the others. Paglieri and Schiappapietra made a positive diagnosis by aspiration of the prostate through the perineum for biopsy, and also of a nodule in one of the cavernous bodies. Guibal and Pavie treated their patient by radium and x-ray, followed by complete emasculation, but do not record the outcome. All the others were terminal cases.

There were two primary carcinomas of the bladder. One was the patient of Neumann, mentioned by both Scheuer and Hinman. This patient, a man of 50, had a cancer of the base of the bladder which

penetrated through the wall. Autopsy revealed cancer invasion of all the veins of the penis and of the cavernous spaces. Priapism was due to an associated cavernitis. Kessell,[20] in 1934, described a malignant papilloma in a man of 39, with extensive metastases, including nodules in the cavernous bodies, with histology identical with the primary tumor. Kessell was able to observe the development of the priapism during the course of the disease.*

Three examples of metastases from primary malignant tumors of the testicle have been published by Froin and Pignot,[21] Bergeret,[22] and Garofalo.[23] In all of these the tumor seems to have been of the seminoma type, and there were extensive generalized metastases. The patients were respectively 52, 31, and 35 years of age.

Gadrat [24] has described the only patient in whom the primary tumor was in the liver. The man was 52 years old and complained of an enlargement and thickening of the penis, with partial erection. Gadrat used the term "false priapism." He had a tremendous liver, filling most of the abdomen. Diagnosis was made by biopsy puncture of the penis, which revealed malignant cells histologically typical of primary cancer of the liver.

As a point of interest, Guibal and Pavie also describe a squamous cell cancer of the cervix, treated by radium, with later metastases in the cavernous bodies of the clitoris. These two were given radium therapy, and subsequently the clitoris was removed. At the time of the report the woman was apparently well. The same authors also mention a cancer of the ampulla of the rectum, with metastases to the bulb and perineal portion of the corpus spongiosum, without invasion of the penis.

SUMMARY

Excluding these last two cases, which do not belong in the series, we have, including our own, eighteen cases of metastatic tumor of the cavernous bodies, of which nine were primary in the prostate, and subject to the criticism already mentioned. Of the remaining nine, all but one were primary in the genito-urinary tract. From the bladder the involvement may have been direct or by either retrograde lymphatic or venous extension. In the case of the more distant tumors, it seems most logical to assume a hematogenous route, especially since, in nearly every case, there were extensive general metastases, including the lungs. The three writers who described the tumors of the testicle all seemed to accept this explanation. An exception is the hypernephroma described by Begg, in which there were no other metastases. Why a tumor should select the cavernous bodies to the exclusion of all other sites is a mystery.

As already mentioned, the priapism was usually incomplete, and with the exception of the prostate cases, the patients were usually able to urinate with some difficulty. Usually the erection came on spontaneously before the patient was seen, but occasionally there had been an operation on the primary tumor, and in one case radium had been implanted into the prostate. In one patient the priapism followed immediately after a cystoscopic examination, and in several there had been such examinations. In my own patient the penis was apparently normal two weeks before the enlargement was noticed, when the man was cystoscoped. Usually the first invasion was in the form of discrete nodules which gradually coalesced. In my own, and in the other case of hypernephroma described by Begg, the involvement was diffuse from the onset. The relative rapidity of growth has been noticed by practically all who observed the condition in its early stages.

Accurate diagnosis was made in two instances by biopsy puncture which revealed malignant tissue in the cavernous body sufficient to make such a diagnosis. In both these cases it confirmed what was already a very strong clinical diagnosis of malignancy. However, since aspiration has been suggested by McKay and Colston [25] as a treatment for priapism, there would seem to be no objection to its use as a diagnostic procedure. Since nearly all the cases were terminal, the only treatment was palliative as a rule, usually deep x-ray to the penis, and in the prostate cases suprapubic cystotomy for the relief of obstruction. In the one case in which complete emasculation was done by Guibal and Pavie, the outcome was not stated.

IN CONCLUSION

The subject is presented on account of its unusual nature and pathological interest. In my own patient the sequence of events made a presumptive diagnosis easy without biopsy, but in doubtful cases the aspiration-trocar method would seem indicated. Despite its rarity, metastatic carcinoma must be considered as a cause of enlargement of the penis and priapism.

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SICKNESS INSURANCE AND HEALTH SERVICE: A DIFFERENCE

WITH SPECIAL REFERENCE TO CALIFORNIA PHYSICIANS' SERVICE*

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THE job of making health service plans work has just begun. A great deal is known about hospitalization and it may be said that this phase is on a fairly accurate actuarial basis. This is probably responsible for the rapid growth of the Blue Cross hospital plan from 32,000 in 1932 to 6,300,000 in 1941. To show the speed with which the idea is taking hold, almost a third of the six million subscribers to hospital plans joined in 1940.

The medical phase of health service plans is a different matter. Until ten years ago the incidence of sickness was virtually unknown. Since then most of our information has come from surveys of one type or another. Most of these have been static in nature and have not shown sickness under conditions where it may be followed from day to day, week to week, month to month, and on. Furthermore, there are practically no usable statistics under health insurance systems adaptable to the American system and quality of medical care. Until such information is available, all designers of health service plans are following a path that offers few markers. California Physicians' Service is the only plan in the United States which is offering a "full medical coverage" on a state-wide basis and without any barriers between the physician and his patient.

CALIFORNIA PHYSICIANS' SERVICE

The weight of experience gained in California Physicians' Service may become all-important if and when the threat of State or Federal Government plans again become imminent. At present we may be having a breathing spell during which we may correct errors.

The 30,000 membership that California Physicians' Service now has is a small segment of the population and exposes each California Physicians' Service physician to an average of five potential patients. However, this membership is large enough to make the wheels of California Physicians' Service turn on a self-supporting basis and to provide experience in all the phases of a medical service plan from the problems revolving around the providing of medical service to individuals to the administrative problems related to care of large groups. There are many things that can and should be tried now with time to do sound planning and not under pressure of political encirclement.

* For news items concerning California Physicians' Service, see page 157.

APRIL TABULATIONS

An analysis of figures for the month of April, 1941, has been made showing the percentage of beneficiary members in each of the twenty-one California Physicians' Service districts, together with the percentage of units of professional service rendered in each district. Interestingly enough, the comparison discloses no wide discrepancies in extent and type of professional service. For example, in Los Angeles and Alameda counties (communities which have almost the same number of members) the cost of medical service differs only one per cent. A comparison on an over-all basis shows that the northern part of the state, with 63.6 per cent of the membership, has used 60.8 per cent of the units of service, while the south with 36.4 per cent of the membership has used 39.2 per cent.

ANALYSIS

According to April figures, the physician-patient load is rather evenly distributed throughout the state, with the single exception of Alameda County, where 6,498 members are served by 547 physicians. The state-wide average is less than four patients per year per physician.

The most important, and perhaps the most alarming, fact that is showing up in studies being conducted in the California Physicians' Service office, is the high incidence of illness. This has been consistently over 17 per cent in the past seven months. A high incidence was expected in the winter months, but it should begin to taper off in February. Instead the high figure for December, an epidemic month, has maintained itself into April. The epidemic is certainly long over, so it cannot be blamed. It is hardly conceivable that one out of every five of the beneficiary members required medical care consistently over a period of seven months. Yet these are the facts as recorded on the California Physicians' Service statistical machines. This extraordinary use of service is naturally burdensome to the whole plan. If the incidence of use of service could remain consistently around 10 or 12 per cent rather than at the present 17 to 19 per cent, California Physicians' Service would very quickly show a very different picture.

The record shows also that a major proportion of California Physicians' Service patients are being treated for minor chronic diseases. That 17 cents of each California Physicians' Service dollar is spent for x-ray and laboratory indicates that physicians are doing very thorough diagnostic work, which is essential to the practice of good medicine. However, this type of diagnostic work is apparently revealing pathology that necessitates continued treatment in a large number of cases. This seems to be borne out by figures showing that the same patients are receiving care month after month.

There are an unhealthy number of cases (from the standpoint of both California Physicians' Service and the health of the community) that continue on indefinitely. It may be that patients are demanding too much service for too many minor things, or it may be that too many doctors are finding too many things wrong with too many people. These

are factors that cannot and should not be subject to administrative action since this is a true expression of the needs of the patient as determined by his own physician.

COMMENT

This suggests a fundamental difference in approach to medical care under health service planning than we have known heretofore. It is well recognized under plans operated by the Government where budgets have to be met that, in order to stretch the budget, benefits are reduced. This reasoning could also be applied to closed systems and contract medicine, where the element of profit is taken into account. It is conceivable that under these plans benefits can be arbitrarly reduced by administrative action, since by so doing profits can be maintained without much difficulty.

Major diseases can be actuarially predicted, but physiologic abnormalities and minor illnesses cannot. It would seem that the fundamental difference between California Physicians' Service, a system in which the beneficiary member has established a relationship with his physician as a private patient, and any system circumscribed by budget or profit controls, is that the physician is going to do a thorough examination, and all pathology relating to the patient's complaint will be disclosed. In so doing, other difficulties not related to the chief complaint may also be discovered and plans made for their future correction. The physician is not restricted in any way by the cost of technical procedures, such as x-ray and laboratory, which relate to diagnosis. Any condition disclosed as the result of such an examination will be treated according to present accepted methods of care, as consistent with the practice of good medicine. This philosophy is in direct contrast to other plans in which administrative influence may limit diagnostic or treatment procedures.

This fundamental difference between the two types of service should be the cause of much speculation on the part of the medical profession. It should be of concern also to the general public, as too often people are not in a position to distinguish between the quality of medical care they are purchasing.

333 Pine Street.

CLINICAL NOTES AND CASE REPORTS

HIPPOCRATES' APHORISMS*

MOSES SCHOLTZ, M. D.
Arcadia

SECTION SIX (Continued)

8. If a patient with dropsy
Gets an ulcer or a sore,
It is hard to heal it quickly
And to normal state restore.

9. Skin lesions which
Are broad, don't itch.

10. Headache located in one spot
Invariably clears
Through drain or serum, or of pus,
From the mouth, nose, or ears.

11. In a melancholic
Or nephritic spell
Hemorrhoids
Augur well.

12. When in a person cured of hemorrhoids
One lesion's left unchecked,
An attack of dropsy or of phtisis
One may expect.

13. When in a violent fit of hiccups
A spell of sneezing does arise,
The hiccups—fit
Abates and dies.

14. If in a case of dropsy
The water drains
Through veins into the belly,
The ailment wanes.

15. If in chronic diarrhea
Vomiting befalls,
Its revulsive action
The malady recalls.

16. In pneumonia
Or pleurisy,
A state of diarrhea
Is bad to see.

17. An attack
Of diarrhea
May relieve
An ophthalmia.

18. Severe wounds of the bladder,
Heart, diaphragm and brain,
Small intestines, stomach, liver
Many deadly threats contain.

19. When bone, cartilage or nerve,
Prepuce or ramus of the jaw,
Are severed, the parts can't be restored
Nor well together grow.

20. If in some abnormal way
Blood seeps into a body-cavity,
It will not stay there uncorrupted,
Nor retain its quality.

21. When varices or hemorrhoids
Arise in melancholic state,
They're apt to be quite beneficial
And may this state alleviate.

22. Pains in the back,
That spread in the direction
Of elbows can be relieved
By venesection.

23. Fright or sadness
Of long duration
Are a mental visitation.

413 Longden Avenue.

(To be continued)

* For other aphorisms, see CALIFORNIA AND WESTERN MEDICINE, March 1940, page 125; April 1940, page 179; May 1940, page 231; July 1940, page 35; August 1940, page 85; September 1940, page 130; December 1940, page 272; January 1941, page 27; February 1941, page 82; March 1941, page 124; April 1941, page 229; July 1941, page 35.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

HENRY S. ROGERS, M.D.....President
WILLIAM R. MOLONY, SR., M.D.....President-Elect
LOWELL S. GOIN, M.D.....Speaker
PHILIP K. GILMAN, M.D.....Council Chairman
GEORGE H. KRESS, M.D.....Sec'y-Treas. and Editor
JOHN HUNTON.....Executive Secretary

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Russel V. Lee, Palo Alto.

Executive Committee:
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Russel V. Lee, Palo Alto.
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General Medicine:
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George H. Houck, Los Angeles.
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General Surgery (including Orthopedics):
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Pharmacology:
Chauncey D. Leake, San Francisco.
Clinton H. Thienes, Los Angeles.

† For complete roster of officers, see advertising pages 2, 4, and 6.

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COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Two Hundred Ninety-Fifth (295th) Meeting of the Council of the California Medical Association

Meeting was held in the Sir Francis Drake Hotel at San Francisco, Sunday, August 10, 1941, at 9:30 a. m.

1. **Roll Call.**

Present: Councilors Philip K. Gilman (Chairman), Henry S. Rogers, William R. Molony, Lowell S. Goin, E. Earl Moody, Elbridge J. Best, Dewey R. Powell, Sam J. McClendon, Edward B. Dewey, Calvert L. Emmons, Louis A. Packard, Axcel E. Anderson, R. Stanley Kneeshaw, John W. Cline, Frank R. Makinson, Frank A. MacDonald, John W. Green, and George H. Kress, Secretary-Treasurer.

Absent: Councilor George D. Maner (ill) and Past President Harry H. Wilson.

Present by invitation: Dr. Dwight H. Murray, Chairman of the Committee on Public Policy and Legislation; Committee from California Physicians' Service—Dr. A. E. Larsen and T. Henshaw Kelly; John Hunton, Executive Secretary; Hartley F. Peart, legal counsel, and Associate Howard Hassard; and Mr. Ben Read, Secretary, California Public Health League.

2. **Minutes.**

(*a*) Minutes of the 291st meeting, held at Del Monte on Sunday, May 4, 1941, were approved. (Abstract was printed in California and Western Medicine, July, 1941, on page 37.)

(*b*) Minutes of the 292nd meeting, held at Del Monte on Monday, May 5, 1941, were approved. (Abstract was printed in California and Western Medicine, July, 1941, on page 37.)

(*c*) Minutes of the 293rd meeting, held at Del Monte on Wednesday, May 7, 1941, were considered. (Abstract was printed in California and Western Medicine, July, 1941, on page 40.) Under item 6, "Committee Nominations to the House of Delegates" (page 41) the word "should" was changed to read "may," the sentence then reading, "It was also agreed that the Sacramento District may have additional representatives on the Committee on Public Policy and Legislation." Upon motion made and seconded, the minutes as amended were approved.

(*d*) Minutes of the 294th meeting, held at Del Monte on Thursday, May 8, 1941, were approved. (Abstract was printed in California and Western Medicine, July, 1941, on page 42.)

3. **Membership.**

(*a*) A report of membership was submitted and placed on file. (Total of 1941 members, dues paid, 6,596; total number of "new members" in 1941 included in the above total, 310; number of 1940 members who have not paid 1941 dues to date, 340.)

(*b*) A list of active members for the year 1940, whose 1941 dues were paid subsequent to the last meeting of the Council (May 8, 1941) was submitted and on motion made and seconded, their active membership for the year 1941 was reëstablished.

The membership of one member whose dues for the years 1940 and 1941 had lapsed and who paid the same subsequent to May 8, 1941, was reëstablished.

(*c*) Since the California Medical Association by-laws provide that retired membership in the Association may be granted only to active members, and because this provision at times creates a seeming hardship, it was voted that the legal counsel draft a proposed amendment which would permit the Council to grant retired membership to a physician who was recorded as having been in active membership within twelve months prior to the filing of the application for retired membership by his component county society, and to submit the same to the Council for consideration.

4. **Financial.**

(*a*) Financial report, as submitted, was accepted and placed on file.

(*b*) Councilor Packard suggested that the reserve funds of the Association might be distributed among a number of banks in order to secure larger returns, and to have federal protection on accounts of certain limited amounts. Motion was made and carried that the Council Chairman appoint a committee to investigate this matter and that the Executive Committee of the Association have power to act in the matter.

(*c*) Concerning Pension Policy for Retired Employees (as noted in the report of the Reference Committee of the House of Delegates, which appeared on page 326 of the June issue of California and Western Medicine) it was voted that the Chairman of the Council appoint a special committee of three to investigate the subject and to report back to the Council.

5. **Resignations.**

The temporary appointment by the Council Chairman of Dr. James F. Doughty of Tracy, as a member of the Committee on Public Health Education, to replace Dr. George H. Rohrbacher of Stockton, now in military service, was approved by the Council.

6. **Basic Science Initiative.**

Reports were made concerning the proposed Basic Science Initiative Act for California.

Councilor Makinson, chairman of the Committee on Public Health Education, stated that the drafts had been completed and that Orange County has been selected as the first place for securing signatures. One of the northern counties will also be used for similar purpose. After sufficient information has been secured as to the best methods of procedure, the petitions will be circulated throughout the State. The importance of proper understanding of the rules laid down by the State, in regard to initiative petitions, was pointed out.

Mr. Hassard, of the legal counsel's office, discussed at some length the various steps involved in securing valid signatures for initiative petitions. The discussion was participated in by Mr. Ben Read of the Public Health League and others. It was stated that, in due course, members of component county societies, Woman's Auxiliaries, the dental profession, and other interested groups would be given complete information.

7. **Medical Services Rendered by Hospital Associations.**

The Special Committee appointed by the Council (July California and Western Medicine, item 7, page 38; item 5, page 39; and item 4, page 41), and consisting of Doctors Gilman and Kress and Mr. Hunton, submitted a report. After discussion, the report was amended and the following was adopted by the Council:

Your committee was named at the May 8, 1941, Council meeting and was instructed to report back to the Council at its next meeting on the question of possible withdrawal of Council approval from hospitalization associations which did not comply with the pronouncements of the American Medical Association on the separation of hospitalization and medical services. The Committee held several meetings in San Francisco with representatives of hospital associations, and enlisted the advice of Doctor L. Henry Garland as a representative of the roentgenologists who are particularly interested in this subject.

On June 7, 1941, the Committee sent to all members of the Council a progress report in which the following tentative conclusions were expressed:

1. That the policies issued by the three nonprofit hospitalization associations in California were, in some instances, contrary to the best interests of all doctors of medicine in so far as their coverage of medical service is concerned.

2. That some hospitals are employing a subterfuge in the collection of professional fees from the hospitalization associations.

3. That advertising and sales promotion literature of the hospitalization associations employs broader language than is used in the associations' contracts with their subscribers.

Your committee requested the comments and recommendations of the members of the Council on these findings and asked that a permanent committee be named by the Council to meet with the hospitalization associations and establish a working basis under which any type of contracts and advertising literature of the associations be made available for inspection by the Council's committee in advance of their publication.

Your committee requests at this time that the Council establish such a permanent committee and empower it to deal directly with the hospital associations along these lines, so that the promotional material and the operating methods of the hospitalization associations may be brought into line with the actual terms of the contracts issued by these associations.

Respectfully submitted,

Philip K. Gilman, M. D.
George H. Kress, M. D.
John Hunton

It was agreed that this committee should also give attention to H. D. Resolution No. 14, concerning hospitalization organizations. (June California and Western Medicine, page 340.)

8. **Annual Session: Hotel Del Monte, May 4-7, 1942.**

(*a*) Tentative designation of the date of next year's annual session, Monday, May 4 to Thursday, May 7, 1942, was approved.

(*b*) Approval was given to the local committee on arrangements appointed by Chairman Gilman: Mast Wolfson, Monterey, Chairman; H. R. Lusigman, Monterey; Curtis B. Gorham, Monterey; Avery Wood, Watsonville; and Joseph M. O'Donnell, Hollister.

(*c*) The Association Secretary informed the Council that conferences had been held with the Hotel Del Monte management whereby it was hoped that a pavilion with additional meeting rooms for some of the scientific sections would be erected.

9. **Editorial Board.**

(*a*) Editor Kress submitted a report for the Executive Committee of the Editorial Board, concerning action taken at a meeting of the Executive Committee, held on Sunday, July 20, 1941. Excerpts from the report follow:

(*a*) Requests of essayists of the Del Monte 1941 program for release with privilege to publish their papers elsewhere. (A number of these requests were granted. Concerning others, the Editor was instructed to write the authors that

it was felt by the Executive Committee that the subject matter and contents were of such type as to merit publication in the OFFICIAL JOURNAL of the California Medical Association.)

(*b*) The Executive Committee then considered in turn the various manuscripts submitted at the Del Monte, 1941, session and made tentative ratings for the information of the Editor.

(*c*) Plans of procedure were then discussed concerning the transmittal of manuscripts to the other members of the Editorial Board. (It was felt that manuscripts written by northern authors should first be sent to members of the Editorial Board living in the south, and vice versa. All communications will be construed as confidential.)

(*b*) Resignation of Dr. George D. Barnett, Chairman of the Editorial Board, was submitted and accepted with regret. Dr. Russel V. Lee was elected chairman of the Board.

(*c*) Changes in the complexion of the Executive Committee of the Board in line with the original resolution were authorized.

10. Committee on History.

Through its chairman, Dr. Morton R. Gibbons, Sr., submitted a report in which attention was called to the need of financial support if the collection of memorabilia was to be inaugurated. Councilor Makinson, former chairman of the committee, stressed the importance of starting this work and called attention to such items as securing the photographs of the early presidents of the California Medical Association.

Upon motion duly made and seconded and carried, the sum of $500 was earmarked to be made available to the Committee on History in carrying on its work.

11. Public Health Exhibits in State and County Fairs.

Association Secretary Kress, who had been placed in charge of public health exhibits at state and county fairs, reported upon the progress that had been made subsequent to the Del Monte annual session in May, 1941, through an appropriation allocation by the Committee on Public Health Education, stating that this would permit transportation costs on exhibits and films, and their proper care to be charged against the budget of the Committee on Public Health Education, in total amount not to exceed $1,000. Excerpts from the report, with informative data, follow:

The first public health exhibit at a county fair was held at Red Bluff in Tehama County, June 12 to 14, and received editorial comment in the July issue of CALIFORNIA AND WESTERN MEDICINE, on page 1.

The Placer District Fair at Auburn followed, June 20-22, and was succeeded by a very creditable exhibit at the Alameda County Fair, held at Pleasanton on July 3-12.

Film presentations at the following fairs:
Stanislaus County Fair at Oakdale, August 1-3.
Sonoma County Fair at Santa Rosa, July 2-9.

Arrangements are under way for film and other presentations at the following fairs:
Humboldt County Fair at Ferndale, August 12-17.
San Joaquin County Fair at Stockton, August 16-24.
Los Angeles County Fair at Pomona, September 12-28.

Councilor Makinson, Chairman of the Committee on Public Health Education, emphasized the value of the publicity which could be carried at fairs through exhibits, films, silent and sound; distribution of literature, as well as through the accessory follow-up meetings brought into being through county fair activities.

12. Woman's Auxiliary.

The value of coöperation by members of the Woman's Auxiliary in promoting the acquisition of valid signatures for the proposed Basic Science Initiative was discussed.

13. California Physicians' Service.

(*a*) A special committee from the Board of Trustees of California Physicians' Service, consisting of Drs. A. E. Larsen, T. Henshaw Kelly, and Dewey R. Powell, presented a plan that had been under consideration by the trustees of California Physicians' Service, the adoption of which might make it possible for California Physicians' Service to secure as beneficiary members the employees of some of the major industrial corporations and industries in California. The plan has to do with a limited surgical benefit contract which could be sold for considerably less than the present sum of $2.50 monthly per person. It was pointed out that among the low-income group citizens, whom California Physicians' Service was particularly intended to benefit, there are many employees who cannot afford to pay the full coverage fee of $2.50 per person for themselves and members of their families.

In some of these major industrial plants, existing setups provide for medical service, on full or part-time, by physicians who look after industrial injuries and minor illnesses. Experience has shown that it would not be possible for an organization such as California Physicians' Service to secure contracts for the care of employees of such organizations if existing provisions in medical service were too greatly disturbed. The problem, therefore, is to find ways and means whereby California Physicians' Service, through full or part-time medical representatives, would be able to take over such work without disrupting existing facilities.

Full discussion on many phases of the issues involved took place. The following motion was then presented by Councilor Powell, and seconded by Councilor Anderson:

Resolved, That the California Medical Association Council give its approval to the Board of Trustees of California Physicians' Service in their endeavor to supply full coverage at reduced rates to large industrial groups, even though this service requires the employment of a salaried plant physician. Under no conditions should such physician so employed accept any California Physicians' Service patients in his private practice that come from that plant.

The vote on this motion was six in favor and nine against, the motion, therefore, being lost.

Recess at this point was taken for luncheon.

13. California Physicians' Service (Continued).

After luncheon, discussion concerning the proposal submitted by the Committee of the Board of Trustees of the California Physicians' Service was continued.

Upon motion by Councilor Packard, seconded by Councilor Makinson, the following resolution was presented:

Resolved, The Council has received the report of the California Physicians' Service and expresses confidence in the ability of the trustees of California Physicians' Service to handle such problems as may arise in the expansion under contracts on an experimental basis.

This resolution was adopted.

(*b*) Concerning the substitute resolution to Resolution No. 3 (June CALIFORNIA AND WESTERN MEDICINE, page 332), concerning appointment of local committees to cooperate with California Physicians' Service, and adopted by the House of Delegates at Del Monte in May, 1941, report was made that the component county societies had been duly notified to appoint coördinating committees to confer upon appropriate occasions with the Board of Trustees of the California Physicians' Service.

14. California State Federation of Labor.

Council Chairman Gilman reported concerning the proposition that was originally submitted by Mr. Edward D. Vandeleur, Secretary of the California State Federation of Labor, relative to the appointment of panels of physicians who might be called upon to treat injuries of citizens who come under the provisions of the California State Industrial Act. (Letter of June 10, 1941, to component county societies.)

General discussion followed. Councilor Cline reported for the special subcommittee, consisting of Doctors Cline, Gibbons, and Howard. On motion duly made and seconded, it was voted that the special subcommittee be requested to continue to act. Chairman Gilman was authorized to appoint two additional members to represent nonmetro-

politan areas. The Committee to continue its studies and bring report thereon to the Council.

15. Survey of California Medical Association Legal Department.

Councilor Gilman presented a report for himself and Doctor Rogers, stating that it had not been possible for Past President Wilson to meet with the Committee, and that, therefore, no survey had been made.

Upon motion duly made and seconded, the Council Chairman was given authority to appoint a committee of three to take up this matter.

16. Committee on Public Policy and Legislation.

Dr. Dwight H. Murray, Chairman of the Committee on Public Policy and Legislation, presented a brief summary of the more important legislation concerning medical practice which came before the California Legislature, recently adjourned. Difficulties having to do with proposed legislation of a controversial nature were outlined. The importance of proper prior understanding was emphasized. Dangers arising from independent, and possible adverse recommendations concerning measures before the Legislature were pointed out. Desirability of having all recommendations first receive the approval of the constituted California Medical Association authorities, or the California Medical Association Committee on Public Policy and Legislation, was stressed.

Mr. Ben Read of the California Public Health League stated that a total of 4,318 bills had been submitted to the last legislature, of which 350 had public health implications; and that of the latter number, almost 100 needed constant attention.

The record at the last legislature was construed to be good in that no antagonistic legislation had gone on to passage and a number of other measures of importance had gone on to enactment. Bills of the California State Board of Medical Examiners, whereby credits for years of practice were somewhat limited, and in which safeguards were inaugurated concerning the granting of licenses to graduates of foreign medical schools, received special comment. Likewise, the bill that safeguards the rights of medical service organizations, such as California Physicians' Service, which are not organized for profit.

Upon motion by Councilor Makinson, duly seconded, the report was accepted and a vote of thanks was extended to the members of the Committee on Public Policy and Legislation and to all physicians and others who had aided that committee in its important work.

In reply, Doctor Murray asked members of the California Medical Association to keep in mind, in their relations as citizens of the State, that it is most desirable to maintain contact with members of the California Senate and California Assembly during the interval between sessions and to extend all possible courtesies.

17. Committee on Public Health Education.

Chairman Makinson spoke of the work which the Committee on Public Health Education was doing through the promotion of public health exhibits in state and county fairs which was being carried on under the immediate supervision of Association Secretary Kress.

Doctor Makinson also stressed the desirability of having medical speakers at conferences such as the California Association of Social Workers, to present pertinent comment on subjects of public health and associated interests.

18. Legal Department.

Legal Counsel Peart spoke on several matters of medical-legal nature: corporate practice, letter to Dr. Victor Hart of Yreka; chiropractic case; Kern County case; California Medical Service associates; and legal costs in a component county medical society case.

Concerning Social Security taxes, Mr. Peart reported that the time within which suit may be brought to seek recovery of Social Security taxes paid in the years 1936 to 1939 has not as yet expired. It was further reported that, although the Council had previously authorized commencement of suit to recover taxes paid on the ground that councilors and officers are not employees, it was the desire of the Legal Department further to study certain recent federal court decisions before actual filing of suit in order to determine whether or not chances of recovery had been affected by recent decisions. It was stated that after such study had been made an additional report with recommendations would be submitted.

19. "California and Western Medicine."

(*a*) The business manager of the OFFICIAL JOURNAL, Executive Secretary Hunton, asked for instructions concerning acceptance of advertisements for wines and spirituous liquors in the OFFICIAL JOURNAL. Discussion of the various phases of the problem followed.

Upon motion by Councilor Kneeshaw, seconded by Councilor Best, it was voted that a certain advertisement, which would bring an income of $600 a year, be accepted, subject to censorship of text, and that other advertisements be accepted if approved. Councilors Moody, Dewey, Makinson, and Emmons voted in the negative.

(*b*) Complying with instructions at the last Council meeting, the business manager of the OFFICIAL JOURNAL, Executive Secretary Hunton, presented bids that had been received from printers in different parts of the state for the printing of CALIFORNIA AND WESTERN MEDICINE. It was shown that if one of the bids was accepted, a substantial saving in the printing bill would be possible each year.

Upon motion by Councilor Goin, seconded by Councilor Moody, it was voted that, at such time as be deemed best, the Executive Secretary be empowered to award the contract for printing CALIFORNIA AND WESTERN MEDICINE to the lowest satisfactory bidder.

20. California Department of Motor Vehicles.

(CALIFORNIA AND WESTERN MEDICINE, June, 1940, pages 271 and 294, Resolution No. 24. In this issue, see page 113.)

The Council's attention was called to a letter received from the California Department of Motor Vehicles asking for the coöperation of the medical profession in choosing the best type of insignia for automobiles of physicians. Purposes of A. B. 690, which amended Section 454 of the California Vehicle Code, is to grant exemption to authorized emergency vehicles of licensed physicians when traveling in response to emergency cases.

The Council authorized a special committee, consisting of the Council Chairman, the Association Secretary, and the Executive Secretary to act for it in the matter of insignia.

21. Request for Loan of California Medical Association Apparatus.

Request of the Radiologic Society of North America for use of certain annual session projection and other apparatus for use at its next annual meeting was granted.

22. Medical Preparedness.

(*a*) Councilor Gilman, having been assigned to active service in the United States Navy, with headquarters in San Francisco, stated that he had found it necessary to submit his resignation as chairman of the California Committee on Medical Preparedness that is working in conjunction with the National Committee on Medical Preparedness of the American Medical Association. Regret was expressed for the necessity of this action, and thanks were extended to Doctor Gilman for his past services.

Upon motion, duly made and seconded, Dr. Harold A. Fletcher, President of the San Francisco County Medical Society, was elected chairman of the California Committee on Medical Preparedness.

(*b*) Certain problems having arisen in California, relative to best ways and means of obtaining highest efficiency in securing military and other personnel designed to promote the highest standards of efficiency and medical preparedness were presented and discussed by several councilors.

It was agreed that a further study of these problems should be left to a committee, consisting of Doctor Fletcher, Chairman of the California Medical Association Committee on Medical Preparedness, Doctor Gilman, and Mr. Hunton. They were to make such report as might be deemed advisable.

23. Committee on Needy Members.

Councilor A. E. Anderson, Chairman of the Subcommittee on Needy Members, made a tentative report. It was agreed that the special committee should meet and elaborate in some detail its plans of procedure with particular reference to expenditure of funds, and that a report be submitted to the Council in order that a general policy in regard to this matter could be definitely outlined.

24. Youth Correction Authority.

President Rogers called attention to a request that had come to him to recommend citizens for certain positions in connection with youth correction authority and requested that councilors or other members feel free to send in their suggestions.

25. Sickness Insurance Fee Schedules.

Councilor Packard called attention to the need of a definite policy in connection with sickness insurance fee schedules. Upon motion duly made and seconded, and carried, a special committee, consisting of Morton R. Gibbons, Sr., San Francisco; Carl Hoag, San Francisco; and Frank A. MacDonald, Sacramento, was appointed to make a study of sickness insurance and Industrial Accident Commission fee schedules, and report thereon to the Council.

26. American Flying Service Foundation.

A letter, dated August 4, was presented by President Rogers, the same having to do with examination of applicants for the flying service. This was referred to the California Committee on Medical Preparedness for further investigation.

27. House of Delegates Resolution No. 10—Hospitalization Subsidy.

Complying with the provisions of Resolution No. 10 (June CALIFORNIA AND WESTERN MEDICINE, page 399), the Council appointed a special committee, consisting of John H. Shephard of San Jose, Wayne Pollock of Sacramento, and Neil Dau of Fresno, to thoroughly study the question of subsidizing hospitalization for all the citizens of California.

28. House of Delegates Resolution No. 12—Payments for Medical Services.

Referring to Resolution No. 12 in re: Payments for medical services, as approved by the House of Delegates at Del Monte in May, 1941 (June CALIFORNIA AND WESTERN MEDICINE, page 339), it was voted that the Chairman of the Council appoint a special committee to make a study of minimum costs of providing medical service as carried on by certain organizations in the State of California, and to bring in recommendations concerning a minimum schedule below which members of such organizations may not be cared for by members of this Association.

29. House of Delegates Resolution No. 8—Selective Service.

(June CALIFORNIA AND WESTERN MEDICINE, page 337.)

Councilor Best, as one of the California Medical Association delegates to the House of Delegates of the American Medical Association, referred to the action taken by the American Medical Association House of Delegates concerning compensation of physicians acting as examiners in Selective Service work. It was agreed that the program outlined by the House of Delegates of the American Medical Association was in line with the policies favored by the California Medical Association.

30. Pasteurization of Milk.

Councilor Emmons called to the attention of the Council certain problems arising in connection with the production and distribution of milk.

Discussion followed, after which a motion was adopted that the Association Secretary communicate with the National and California Certified Milk Commissions and the California Medical Association Section on Pediatrics and other agencies in an effort to secure information to be embodied in a report to be submitted to the Council.

31. Medical Publication.

A letter, dated June 6, 1941, received from Councilor Moody in reference to a medical publication printed in California was presented. After discussion, upon motion by Councilor Green, seconded by Councilor Packard, it was voted that the communication be placed on file.

32. Date and Place of Next Meeting.

It was voted that the next meeting of the Council be held in Los Angeles on Sunday, October 26, 1941, the Council to convene at 9:30 a. m.

33. Adjournment.

PHILIP K. GILMAN, *Chairman.*
GEORGE H. KRESS, *Secretary.*

CALIFORNIA COMMITTEE ON MEDICAL PREPAREDNESS†

Federal Agency to Select Defense Doctors

In the interests of national defense, the establishment at the earliest possible moment of a federal agency for the procurement and assignment of physicians for military, civilian, and industrial service is urged in an editorial in the July-August issue of *War Medicine*, published bimonthly by the American Medical Association, Chicago, in coöperation with the Division of Medical Sciences of the National Research Council, Washington, D. C. . . .

Already it is apparent that the procurement and assignment of physicians in the United States for some of the innumerable calls which are likely to be made on them in the near future are going to be a task that will take the best available information and organizational ability. Apparently the needs for medical personnel which must be supplied are about as follows:

1. The United States Army Medical Corps and the United States Army Medical Reserve Corps.
2. The United States Navy Medical Corps and the United States Navy Medical Reserve Corps.
3. Physicians for the United States Public Health Service.
4. Physicians for the Selective Service Administration, including local boards and appeal boards.
5. Physicians for civilian medical service.
6. Physicians for aid to Britain, requested by the American Red Cross.
7. Physicians for industrial medicine.
8. Physicians for service in rehabilitation.
9. Physicians for civilian defense organization.
10. Physicians for state and county medical and public health organizations.

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the chairman of the California Committee on Medical Preparedness. Charles A. Dukes, M. D., 426 Seventeenth Street, Oakland, is a member of the American Medical Association Committee on Medical Preparedness. Roster of county chairmen on Medical Preparedness appeared in CALIFORNIA AND WESTERN MEDICINE, August, 1940, on page 86.

11. Physicians for medical divisions in other government services.

Already the American Medical Association has available on a punch-card system the names of more than 160,000 American physicians licensed to practice, with complete information regarding their ability and availability for many different types of medical service. Nevertheless, the utilization of this material must await the establishment of some agency capable of acting with authority for purposes of procurement and assignment of physicians in times of emergency. If such a federal procurement agency is to be of the greatest possible service, it should be organized and ready to function before the moment when it is most needed. It would be well if the national administration could give prompt consideration to the desirability of establishing an agency of this kind at the earliest possible moment.

* * *

Volunteer Nurses' Aides

(COPY)

OFFICE OF CIVILIAN DEFENSE

WASHINGTON, D. C.

August 15, 1941.

To the Editor:—The Medical Division of the Office of Civilian Defense will attempt to keep your Association informed of all medical and public health activities of this office. Unless otherwise indicated, your Association is at liberty to publish in its state journal (CALIFORNIA AND WESTERN MEDICINE) the material which you will receive. I would also request that you transmit such information to your constituent county associations. . . .

Enclosed is a statement concerning the training of one hundred thousand volunteer nurses' aides by the Office of Civilian Defense and the American National Red Cross, which you may wish to use.

Within the next week, I shall send Bulletin No. 1 of the Medical Division of the OCD (Office of Civilian Defense), on the organization of emergency medical services in each area. It is important that this information be in the hands of every physician in your state so that he may understand the rôle which he may play in civilian defense.

Very truly yours,

(Signed) GEORGE BAEHR, M. D.,
Chief Medical Officer.

* * *

TRAINING OF VOLUNTEER NURSES' AIDES

The United States Director of Civilian Defense, Mayor F. H. LaGuardia, announces the training of 100,000 volunteer nurses' aides during the next twelve months, in collaboration with the American National Red Cross and the major hospitals of the country. The program is in preparation for a great expansion in hospital beds which may be required during the national emergency, at a time when the already overburdened nursing facilities of civilian hospitals are seriously depleted due to the demands of our military and naval establishments and the increasing needs of public health and industrial hygiene services.

The growing deficiency in hospital personnel is now being met in part through the training of large numbers of paid subsidiary hospital workers by the NYA, WPA, and other agencies. The training program for volunteer nurses' aides is designed to expand the effectiveness of the trained nurse in hospitals, clinics, and field nursing services by supplying her with intelligent assistants who can work under her direction.

The curriculum of instruction has been prepared by the Medical Division of the Office of Civilian Defense, the American National Red Cross, and the Federal Security Agency. Eligibility is limited to women between the ages of eighteen and fifty who have had at least a high school education or its equivalent, and who are physically fit. The course will provide eighty hours of intensive instruction in a period of seven weeks. The first half of the course will be given in the local Red Cross Chapter house in collaboration with local hospitals and nursing organizations. This will constitute the probationary period and will require two hours of instruction daily on five days a week for four weeks.

The second half of the course will consist of supervised practice in a hospital which has been designated by the Office of Civilian Defense and the Red Cross as a training center. The American National Red Cross will assist the hospital to provide competent instructors and nursing supervisors.

Those who complete the course will be enrolled in the Volunteer Nurses' Aide Corps of the American Red Cross with the assurance that they will play an important rôle in civilian defense. They will retain their membership in the Corps only as long as they continue to render adequate service during the period of the national emergency. This is defined as 150 hours of volunteer service in a hospital, clinic, or field nursing organization in at least one three-month period in each calendar year.

The Office of Civilian Defense and the American National Red Cross will provide for this continuing service by arrangement with local hospitals and field nursing agencies. For this purpose, the Red Cross will maintain a Placement Bureau, which will allocate volunteer nurses' aides to the following types of nursing service: hospitals and clinics, visiting nurse (home visiting) agencies, health departments, school health services, and industrial hygiene clinics.

By serving in this manner as assistants to qualified nurses, their training will be continued. In the event of sudden emergencies during a period of national crisis, they will then be immediately available for reassignment to hospital or field duty by the Office of Civilian Defense. There will be opportunity for some to serve as members of the Mobile Medical Field Units which are being organized in hospitals along both seaboards and in industrial centers in the interior, according to plans announced this week by the United States Office of Civilian Defense.

Volunteer nurses' aides will wear the uniforms and insignia of civilian defense. The new insignia for nurses' aides will be a red cross within the triangle and circle of the Office of Civilian Defense, indicating that the aide was enrolled and trained by the Red Cross to serve in civilian defense.

Applicants may enroll at the Red Cross Chapter house, and the course will begin in each locality as hospital arrangements are completed.

* * *

Physicians for Britain*

The following facts, with respect to foreign service for American physicians, were published in *The Journal of the American Medical Association*: [1]

By June 23, 1,343 inquires had been received; 643 applications had been mailed in response to the inquiries received; 69 physicians who applied had been rated as professionally unqualified; 67 had been pronounced professionally qualified, but of these, two have withdrawn their applications; 52 applicants are awaiting the decision of the committee; and 33 have been pronounced eligible for a visa. Fifteen applicants are now in process of having physical examinations completed, and seventeen have been pronounced physically fit. Actually, two men have been granted United States passports and fifteen have reached the stage where they are awaiting passports. The total figure of physicians apparently ready to go or likely to be made available is about sixty-five, with an additional twenty-five still in process before the committee. This will mean that by the middle of July approximately ninety men will be the response to the request.

Since the announcement was first made a statement has come from Great Britain authorizing the acceptance of married physicians, who will be on the same basis, salary, and allowances as unmarried men, except when the total pay for British married officers of the same rank exceeds that for American single men; in such cases the higher rate will then be paid. For the emergency medical service married men will be accepted on the same terms as are single men. The British Red Cross also announces that ten women with equal qualifications will be acceptable on the same terms as are men. With these additional announcements seventeen more physicians, formerly considered ineligible, become eligible.

The *Journal* comments further:

The total response to the request from Great Britain is not especially gratifying. In explanation, it may be pointed out that American medical publications and organizations have been repeatedly informed that our own need for physicians is considerable and will be met only with the greatest of difficulty. Already one medical school has announced an increased enrollment of 10 per cent to meet the increased demand for medical men. However, increasing enrollments in medical schools will not make additional

* From the *New York State Journal of Medicine*, August 15, 1941.

[1] J. A. M. A., 117, No. 1, 37 (July 5) 1941.

physicians available until six years from now. The news from abroad and from Washington seems to indicate constantly the threat of the entrance of our own nation into the war. This also has unquestionably influenced many physicians to withhold enlistment in any military service until the needs of our own country shall have been satisfied.

* * *

AMERICAN DOCTORS FOR BRITAIN

Sir:—I am much interested in this subject now before the profession from an experience during the last war, when I occupied the position of chairman of the Recruiting Medical Boards for Cumberland at Carlisle, where thousands of men were examined. I have no hesitation in expressing the view that the present arrangements are superior to 1914–1918, and if they were effected to the full there should be little need for the emergency call for 1,000 American doctors at this time. But it is not so, for although a large number of available British doctors have already registered in the ordinary course, comparatively few have been posted to date.

During the recruiting period of the last war, applications for posts on medical boards were received from qualified men hailing from several other countries, and a number were accepted, but temperamental variation and habitude barred the way to good coöperation and harmony; acute friction resulted with consequent resignation, with the result that the whole clinical system extant suffered acutely. I would like to be informed why so many English doctors, quite dispensable for service, under the age of thirty have not been called up and are enjoying seclusion in their own practices. I am satisfied that if the committees in authority for absorbing all the available medical man power were exhaustively conducted, there would be little need for the emergency call to the Western Hemisphere, initiating an anomalous position. During the last war medical man power was reduced to an absolute minimum, and only a fraction of the medical community was left to carry on medical practices—in fact, a dangerous position was reached. At the present time, however, the general health of the nation is good, and the vital intelligence of the people is such that this should be maintained for the remainder of the war. I am, etc.,

C. W. Graham, J. P.,
Ex-President of the Border Counties Branch, British Medical Association.

—*British Medical Journal*, 834 (May 31), 1941.

Silloth, May 13, 1941.

* * *

The Medical Officer "Sounds Off"

Quoting from an article appearing in the *Daily Oklahoman* of Friday, May 9, 1941, under the date line of Del Monte, California.:

Lieutenant-Colonel John H. Schaefer, Medical Corps, United States Army, addressing the California State Medical Association, says: "Too many young doctors holding Reserve commissions are attempting to evade their duty by seeking exemptions from army service in the present emergency. The time has come to call a spade a spade. The number of such slackers is too numerous."

It is poor taste for an army officer to try to dictate to the medical profession its responsibility. Every doctor has his own problem to solve and should do what his conscience dictates to be the right thing and when he has made the decision, the calling of mean names will never improve the situation.

It is, unfortunately, true that we do not all see "eye to eye" in this present emergency. We must all conduct ourselves as professional men, even though the courts in Washington have said we are not, but it is hard to expect physicians to make 100 per cent sacrifice while the members of the other "trades" are holding up production and demanding more pay.

By army regulations a first lieutenant who is married, has dependents and no source of income except from his profession, may resign his commission. Some physicians, after deliberate consideration, have decided to accept this regulation and if the regulation is a good one he can hardly be criticized for so doing. Should such action brand a physician a slacker? If so, the regulation is bad.

If a doctor prefers to register under the Selective Service Act, it is entirely his personal affair as he is doing the very thing the Government has planned for him to do and is not subject to any criticism or slanderous names from any Government agency.

Let each doctor search his heart, decide as to his course of action, then act accordingly.

Now let Government agencies try some better manner than nasty names to develop a coöperative spirit and unanimity of action from the medical profession.

Give and then give more to this program of preparedness, but let this be according to the dictates of your own conscience and your own patriotism, not because some medical officer of the United States Army proposes to classify you as a slacker. —*Journal of the Oklahoma State Medical Association.*

* * *

Medical Aid for Rejected Draftees Is Recommended

Alarmed because of the high percentage of rejections under the Selective Service Act, Social Security Administrator Paul V. McNutt recommended that corrective medical treatment be provided at Government expense.

He would limit the rehabilitation program to those who request it; and to cases in which minor corrective measures would suffice, such as remedying defects involving teeth, eyes, ears, nose and throat, and treatment for venereal disease. How large an appropriation would be necessary to finance such a program has not been estimated.

Presumably, a registrant who discovered through the military service physical examination that he had such defects should be willing to undertake their correction himself. But means to do so often is lacking; and McNutt believes little will be accomplished without public assistance.

* * *

The Selective Service Act is concerned primarily with obtaining the required man power for the nation's armed services, but it would be folly to overlook the social questions raised. As McNutt well says:

"While this program is directed primarily toward making more men available for military service, it has far greater implications on the future public health of the country, particularly in relation to the opportunities for the replacement of these registrants into civilian pursuits after the emergency is over."

If the country fails to profit through the Selective Service Act findings concerning the general health of her people, she is pursuing a short-sighted policy.—Sacramento *Bee*, August 19.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION†

For the information of members of the California Medical Association, a list of bills having relation to public health matters, and to medical practice standards, and introduced by Senators or Assemblymen in this year's California Legislature, appears below. The list was compiled by Mr. Ben Read, Secretary of the Public Health League of California. The acts that went on to full enactment become operative about September 13. (For editorial comment, see page 113.)

Antivivisection

Assembly Bill 920, by Voight (referred to Committee on Public Health and Quarantine), regulating the conduct of pounds, prescribing duties of persons in charge thereof, or employed thereat, and regulating the disposition of animals impounded or sheltered therein.

Died in Committee.

* * *

Board of Health

Assembly Bill 977, by Waters (referred to Committee on Public Health and Quarantine), places director in charge of department and gives him all duties and powers previously vested in State Board of Public Health. Board of six members to be solely advisory.

Died in Committee.

* * *

Chiropody

Assembly Bill 2144, by Johnson (referred to Committee on Medical and Dental Laws), relating to instruction in chiropody.

Assembly Bill 2145, by Johnson (referred to Committee on Medical and Dental Laws), relating to the advertising of chiropodical services.

Both of the above bills passed the Legislature and were approved by the Governor.

† Component County Societies and California Medical Association members should not give endorsements to proposed legislation unless the California Medical Association Committee on Public Policy and Legislation has so requested. On such matters, address: California Medical Association Committee on Legislation, Dwight Murray, M. D., Chairman, 450 Sutter, San Francisco. Telephone, DOuglas 0062.

Chiropractic

Assembly Bill 208, by Middough (referred to Committee on Insurance), includes chiropractors as "physicians" to render service in Workmen's Compensation cases.

Assembly Bill 1988, by Thomas (referred to Committee on Insurance), medical treatment under Compensation Act to include chiropractic.

Assembly Bill 2247, by Salsman (referred to Committee on Medical and Dental Laws), relating to chiropractic treatment of injured employees under Compensation Act.

Assembly Bill 2383, by Desmond (referred to Committee on Medical and Dental Laws), re'ating to Board of Chiropractic Examiners.

Assembly Bill 2511, by Lyon (referred to Committee on Medical and Dental Laws), amending Chiropractic Act.

Assembly Constitutional Amendment 47, by Desmond (referred to Committee on Constitutional Amendments), ratifying changes that may be made by Fifty-fourth Legislature in Chiropractic Act.

All of the above bills died in committee.

* * *

Clinics

Assembly Bill 2439, by Watson (referred to Committee on Public Health and Quarantine), amends Health and Safety Code relating to clinics and dispensaries.

Died in Committee.

* * *

Clinical Laboratories

Assembly Bill 596, by Burns, Hugh M. (without reference to Committee), codifies laws relating to regulation of clinical laboratory technologists and clinical laboratory technicians.

Passed the Legislature and approved by the Governor.

Assembly Bill 1507, by Green (referred to Committee on Governmental Efficiency and Economy), an act to establish a "State Board of Medical Laboratory Personnel Examiners," to regulate clinical laboratory technologists and technicians.

Died in Committee.

* * *

County Hospitals

Assembly Bill 1037, by McCollister (referred to Committee on Governmental Efficiency and Economy), relating to administration of county hospitals.

Died in Committee.

* * *

Dentistry

Assembly Bill 482, by Andreas (referred to Committee on Medical and Dental Laws), re'ating to practice of dentistry.

Died in Committee.

Assembly Bill 1148, by Leonard and Johnson (referred to Committee on Education), relating to absence of pupils from school for dental services.

Passed the Legislature and approved by the Governor.

Assembly Bill 1449, by Cronin (referred to Committee on Medical and Dental Laws), relating to powers and duties of Board of Dental Examiners.

Died in Committee.

Assembly Bill 1450, by Cronin (referred to Committee on Medical and Dental Laws), relating to examinations.

Passed the Legislature and approved by the Governor.

Assembly Bill 1451, by Cronin (referred to Committee on Medical and Dental Laws), relating to complaints.

Passed the Legislature and approved by the Governor.

Senate Bill 720, by DeLap (referred to Committee on Business and Professions), re'ating to revocation or suspension of licenses.

Died in Committee.

Senate Bill 1130, by Swan (referred to Committee on Business and Professions), relating to employment of licensed dentists.

Died in Committee.

* * *

Dispensing Opticians

Assembly Bill 1452, by Cronin (referred to Committee on Medical and Dental Laws), relating to fees for certificates.

Passed the Legislature. Vetoed by the Governor.

Assembly Bill 1453, by Cronin (referred to Committee on Medical and Dental Laws), re'ating to application fees.

Passed the Legislature and approved by the Governor.

Assembly Bill 1454, by Cronin (referred to Committee on Medical and Dental Laws), relating to change of address on certificates.

Passed the Assembly. Died in Senate Committee.

* * *

Drugless Practitioners

Assembly Bill 1853, by George D. Collins and O'Day (referred to Committee on Insurance), permits drugless practitioners to treat cases under Workmen's Compensation Act.

Assembly Bill 2089, by Desmond (referred to Committee on Medical and Dental Laws), removes drugless practitioners from license under Board of Medical Examiners.

Both of the above bills died in Committee.

* * *

Health Insurance

Assembly Bill 1730, by Thomas and Cain (referred to Committee on Unemployment), Compulsory Health Insurance.

Assembly Bill 2471, by Kilpatrick (referred to Committee on Governmental Efficiency and Economy), establishing a tax-supported system of Health Insurance, providing for the administration thereof and defining the scope of treatment thereunder.

Senate Bill 645, by Swan and Kenny (referred to Committee on Welfare and Institutions), Compulsory Health Insurance.

Senate Bill 1024, by Kenny (referred to Committee on Labor), encouraging employers to provide for health and security of their employees, providing revenue to the State for aid of those persons dependent upon it.

All Health Insurance bills died in Committee.

* * *

Herbalists

Assembly Bill 1349, by Lyon (referred to Committee on Medical and Dental Laws), requiring Board of Medical Examiners to issue herb practitioners' certificates.

Died in Committee.

* * *

Hospitals

Assembly Bill 357, by F. N. Howser (referred to Committee on Public Charities and Corrections), re'ating to contracts for care of indigents in private hospitals.

Passed the Legislature. Approved by the Governor.

Assembly Bill 1683, by Poulson (referred to Committee on Judiciary Codes), provides liens in favor of hospitals for services to injured persons.

Passed the Legislature. Vetoed by the Governor.

Assembly Bill 1732, by Cain (referred to Committee on Governmental Efficiency and Economy), relating to furnishing of hospital services by employers to employees and former employees.

Assembly Bill 2329, by Clarke (referred to Committee on Judiciary General), re'ating to an action against hospitals for discrimination against physicians and surgeons.

Assembly Bill 2509, by Hastian (referred to Committee on Medical and Dental Laws), identical with Assembly Bill 2329.

Senate Bill 204, by Fletcher (referred to Committee on Judiciary), relating to liability of charitable hospitals for injury or death of patients.

Senate Bill 245, by Quinn (referred to Committee on Public Health and Safety), provides not less than $50 per month compensation for interns.

All of the above bills died in Committee.

* * *

Massage

Assembly Bill 51, by Salsman, Clarke, Doyle, Del Mutolo, Richie, and Poo'e (referred to Committee on Governmental Efficiency and Economy), regulation and government of persons engaged in the practice of massage.

Died in Committee.

* * *

Medical Examiners, Board of

Assembly Bill 380, by Cronin (referred to Committee on Medical and Dental Laws), relating to grounds for disciplinary action under the chapter on medicine.

Died in Committee.

Assembly Bill 413, by Pfaff (referred to Committee on Medical and Dental Laws), relating to the directory.

Assembly Bill 481, by Andreas (referred to Committee on Medical and Dental Laws), relating to practice of medicine.

Assembly Bill 502, by Cronin (referred to Committee on Medical and Dental Laws), relating to fees and certificates.

Assembly Bill 503, by Cronin (referred to Committee on Medical and Dental Laws), relating to examinations.

Assembly Bill 504, by Cronin (referred to Committee on Medical and Dental Laws), relating to use of addressing facilities of the Board.

Assembly Bill 505, by Cronin (referred to Committee on Medical and Dental Laws), relating to reports of the Board.

All of the above bills passed the Legislature and were approved by the Governor.

Assembly Bill 1475, by Pfaff (referred to Committee on Medical and Dental Laws), relating to applications for physicians' and surgeons' certificates by graduates of foreign medical schools.

Passed the Legislature. Vetoed by the Governor. Veto overridden.

Assembly Bill 1497, by Cain (referred to Committee on Medical and Dental Laws), relating to advertising of medical business.

Passed the Legislature and vetoed by the Governor.

Assembly Bill 2088, by Desmond (referred to Committee on Medical and Dental Laws), relating to advertising of medical business.

Passed the Legislature. Approved by the Governor.

Senate Bill 1129, by Swan (referred to Committee on Business and Professions), relating to employment of physicians and surgeons or osteopaths.

Died in Committee.

* * *

Medical Research

Senate Bill 1032, by Swan (referred to Committee on Governmental Efficiency), providing for a Medical Research Board, prescribing powers and duties thereof and making an appropriation.

Died in Committee.

* * *

Medical Service

Assembly Bill 562, by Cronin (referred to Committee on Medical and Dental Laws), authorizing nonprofit membership medical service corporations to contract with Federal agencies and receive and administer in trust Federal funds.

Passed the Legislature. Vetoed by the Governor.

Assembly Bill 563, by Cronin (referred to Committee on Corporations), formation and purposes of nonprofit corporations.

Passed the Legislature and approved by the Governor.

Assembly Bill 2148, by Johnson (referred to Committee on Corporations), relating to nonprofit hospital service plans.

Died in Committee.

* * *

Military Service

Assembly Bill 303, by Cronin (referred to Committee on Medical and Dental Laws), relating to fee and tax exemptions.

Passed the Legislature and approved by the Governor on February 3.

Assembly Bill 811, by Waters and Poulson (referred to Committee on Military Affairs), relating to licenses for persons who have served in the armed forces.

Passed the Legislature. Approved by the Governor.

* * *

Motor Vehicles

Assembly Bill 690, by Sawallisch (referred to Committee on Motor Vehicles), to provide for the inclusion within the exemptions granted to authorized emergency vehicles of licensed physicians when traveling in response to emergency calls.

Assembly Bill 1489, by Sawallisch and Cronin (referred to Committee on Public Health and Quarantine), relating to reporting of cases of epilepsy.

Assembly Bill 2453, by Gunlock (referred to Committee on Judiciary Codes), relating to transportation, care, and treatment of persons injured upon highways.

All of the above bills passed the Legislature and were approved by the Governor.

* * *

Narcotics

Assembly Bill 1987, by Thomas (referred to Committee on Medical and Dental Laws), relating to permits to keep narcotics in hospitals.

Passed the Legislature and approved by the Governor.

Assembly Bill 2389, by Dickey (referred to Committee on Public Health and Quarantine), repealing sections relating to prescriptions for drugs and narcotics.

Died in Committee.

Senate Bill 1186, by Phillips (referred to Committee on Governmental Efficiency), transferring division of Narcotics Enforcement to Department of Public Safety.

Died in Committee.

Senate Bill 1313, by Metzger (referred to Committee on Public Health and Safety), relating to narcotics.

Passed the Legislature and approved by the Governor.

* * *

Naturopath

Assembly Bill 1301, by Richie, Pelletier, and Kilpatrick (referred to Committee on Medical and Dental Laws), establishing a State Board of Naturopathy.

Died in Committee.

Senate Bill 977, by Swan (referred to Committee on Governmental Efficiency, creates Board of Naturopathic Examiners.

Refused passage by the Senate.

Nursing

Assembly Bill 1426, by Bashore (referred to Committee on Civil Service), relating to undergraduate nurses and practical nurses.

Died in Committee.

Assembly Bill 1915, by Cronin (referred to Committee on Medical and Dental Laws), relating to trained attendants.

Passed the Assembly. Died in Senate Committee.

Assembly Bill 1882, by Hawkins (referred to Committee on Governmental Efficiency and Economy), relating to Board of Nurse Examiners' Fund.

Passed the Legislature. Approved by the Governor.

Assembly Bill 2051, by Cronin (referred to Committee on Medical and Dental Laws), relating to practice of and training for nursing.

Senate Bill 718, by Swan (referred to Committee on Business and Professions), relating to undergraduate nurses and practical nurses.

Both of the above bills died in Committee.

* * *

Optometry

Assembly Bill 2264, by Turner (referred to Committee on Medical and Dental Laws), relating to disciplinary actions.

Assembly Bill 2267, by Lyon (referred to Committee on Medical and Dental Laws), relating to admission to practice optometry.

Above bills died in Committee.

Assembly Bill 2299, by Meehan (referred to Committee on Medical and Dental Laws), relating to offenses.

Passed the Assembly. Failed to pass the Senate.

Assembly Bill 2457, by Johnson and Cain (referred to Committee on Medical and Dental Laws), relating to training of persons seeking an optometry license.

Passed the Legislature. Approved by the Governor.

Senate Bill 1124, by Jespersen and McBride (referred to Committee on Public Health and Safety), relating to clinics and dispensaries.

Passed the Legislature. Approved by the Governor.

Senate Bill 1125, by Jespersen and McBride (referred to Committee on Public Health and Safety), relating to employment of optometrists by cities and counties.

Died in Committee.

* * *

Osteopaths

Assembly Bill 2358, by Watson (referred to Committee on Governmental Efficiency and Economy), relating to license fees of the Board of Osteopathic Examiners.

Passed the Legislature. Approved by the Governor.

* * *

Physical Examinations

Assembly Bill 1570, by F. F. Houser (referred to Committee on Public Health and Quarantine), an act to require cooks, bus boys, waiters, waitresses, dish washers, dish dryers, and domestic servants to obtain certificates that they are free from communicable diseases.

Passed the Assembly. Died in Senate Committee.

Assembly Bill 2474, by Kirkpatrick (referred to Committee on Public Health and Quarantine), relating to medical examination of persons handling food or food containers intended for the consumption of others.

Died in Committee.

Senate Bill 788, by Mixter (referred to Committee on Education), relating to physical examination of teachers for active tuberculosis.

Passed the Legislature. Approved by the Governor.

* * *

Premarital Examinations

Assembly Bill 1854, by George D. Collins (referred to Committee on Public Health and Quarantine), providing "drugless physicians" may make premarital examinations.

Died in Committee.

* * *

Pounds

Senate Bill 488, by Gordon (referred to Committee on Public Health and Safety), relating to conduct of pounds, the disposition of animals impounded or sheltered therein. Humane Pound Act.

Died in Committee.

* * *

Relief

Assembly Bill 1625, by Cronin, Wollenberg, Poulson, and Gallagher (referred to Committee on Medical and Dental Laws), establishing a medical and dental program for persons receiving assistance from the public moneys of this State.

Assembly Bill 1694, by Turner (referred to Committee on County Government), authorizing boards of supervisors to

contract for hospitalization and medical care for migrant farmers, farm laborers, or low-income farmers.

Both of the above bills died in Committee.

* * *

Sales Tax

Assembly Bill 723, by Massion, Bennett, Hawkins, Pelletier, Thomas, Russell, Doyle, Burkhalter, Evans, Lowrey, George D. Collins, and Cain (referred to Committee on Revenue and Taxation), relating to exemptions of medicines and drugs.

Passed the Assembly. Died in Senate Committee.

Senate Bill 130, by Swan (referred to Committee on Revenue and Taxation), relating to the exemption of drugs.

Died in Committee.

* * *

Workmen's Compensation

All bills of interest to the medical profession died in Committee.

* * *

Miscellaneous

Assembly Bill 2, by Bashore (referred to Committee on Unemployment), relating to eligibility of sick persons for unemployment benefits.

Died in Committee.

Assembly Bill 1014, by Johnson (referred to Committee on Insurance), relating to preëxisting disease, previous injury or previous vocational handicap in compensation cases.

Died in Committee.

Assembly Bill 1065, by Bashore (referred to Committee on Medical and Dental Laws), relating to prevention of blindness at childbirth.

Passed the Legislature. Approved by the Governor.

Assembly Bill 1883, by Dills, Bennett, and Green (referred to Committee on Education), authorizing school districts to pay certain medical expenses for injuries received by pupils.

Died in Committee.

Senate Bill 302, by Fletcher (referred to Committee on Judiciary), relating to rights of unborn children and providing for limitation of actions for prenatal injuries and injuries sustained in the course of birth.

Passed the Legislature. Approved by the Governor.

* * *

Compulsory Health Insurance in California: Commonwealth Club

San Francisco.—In opposing compulsory sickness insurance for California by a vote of 871 to 491, the Commonwealth Club of California took two new factors into consideration:

1. Two and a half years of operation of the voluntary sickness insurance plan sponsored by the medical association, the California Physicians' Service, and

2. Rejections of draftees for failure to comply with the physical requirements of the Army.

The Club's secret vote followed a fifteen-month study by its Public Health Section, largely composed of physicians and surgeons, which opposed compulsory sickness insurance 94 to 20. The Section's study and presentation of the majority and minority reports comprise a thorough study of compulsory sickness insurance. It is entitled, "Compulsory Health Insurance."

In arguing that sickness insurance, like life insurance and fire insurance, should be kept in the field of private enterprise, Frank M. Kaye, an optometrist and member of the Public Health Section, disclosed that the California Physicians' Service is served by more than 5,000 physicians and in its first eighteen months had acquired more than 20,000 subscribers.

Presenting the majority report against compulsory sickness insurance, Mr. Kaye affirmed that the Club Section approved sickness insurance on a private basis. In the past six years, he said, hospitalization insurance under nonprofit systems had taken root in more than sixty cities in the country and it covers more than 6,000,000 persons at a cost of 50 cents to 85 cents a person a month. Insurance for all types of medical care, including hospitalization, can be obtained for $2.50 to $3 a month, it was pointed out.

While agreeing with the minority argument that private insurance would not afford all persons coverage as completely as would compulsory insurance, the Club members arguing against compulsion pointed out that there were other objections to compulsion which should be considered.

In answering the argument that because 50 per cent or more of the men examined for the draft the past year had been turned down because of some defect, supposedly showing a great need for medical attention, Dr. Alson R. Kilgore, a surgeon, explained that only 10 per cent of the men turned down had physical defects subject to medical treatment.

Doctor Kilgore said he had been examining men for a draft board in a San Francisco district, supposedly containing a high number of unemployed and poorly nourished persons. Over half of those rejected, he said, had technical dental deficiencies, and some had optical difficulties not subject to medical treatment. Although the Army could not take these men, Doctor Kilgore said, so far as the men themselves were concerned, they were in good condition.

From a taxpayers' point of view, Dr. Eugene S. Kilgore, a physician, pointed out that a state insurance system would be a bureaucratic millstone the taxpayers would have to carry. Should there be partial relief from the $13,500,000 annual cost of county hospitals, what about the cost of the new system at $21,000,000 a year or geater? he asked.

Taking California's experience in compulsory industrial accident insurance, Dr. Carl L. Hoag, surgeon, assailed the bureaucratic costs of the system. Industrial accident insurance in California costs $50,000,000 a year, Doctor Hoag said. Of this, only $8,000,000 is paid to doctors in fees. The rest, apparently, goes into the system. Although rates technically allowed doctors under the law grant them 15.6 per cent of the money, they are only getting about 8 per cent, Doctor Hoag declared. He pointed out that only one-fifth of total sickness costs in California are covered by accident insurance, concluding with this question:

"If accident insurance costs $50,000,000 per year and is one-fifth of total illness, what will be the bill for compulsory health insurance when it is fully expanded? How many people realize that if the doctor worked for absolutely nothing, accident insurance would still cost $42,000,000 per year and that there is every reason to expect that compulsory health insurance would cost the same proportionate amount for other than doctors' services?"

Reasons presented by the majority of the Public Health Section against compulsory sickness insurance can be summarized:

1. It would destroy the individual incentive of the medical profession.

2. It would impose a costly bureaucratic system on taxpayers, and make necessary a complicated pay-roll audit system on top of current tax computations on pay rolls.

3. It will encourage people to be sick, to ask for unnecessary prescriptions, and to seek hospitalization unnecessarily.

4. Just because foreign countries have compulsory sickness insurance is no reason for the United States to adopt it. In Europe the lay jobholders of governmental sickness insurance schemes have gradually multiplied until they equal or exceed the number of physicians employed.

5. Compulsory sickness insurance would be class legislation which would adversely affect employers with high pay-roll costs, corner druggists, optometrists, and x-ray operators; practitioners other than doctors of medicine, and their patients who would be subjected to a pay-roll tax without receiving any of the so-called benefits of the system. Only 60 per cent of healing practitioners in California are doctors of medicine.

6. Compulsory sickness insurance would infringe the religious liberty of Christian Scientists.

7. Liberty is more valuable to the American people than any kind of health security, and compulsory sickness insurance is the road to collectivism.

8. In view of rapidly rising private sickness insurance systems, the need for a compulsory state system has not been demonstrated.

Arguments presented in favor of a state system dealt most extensively with the asserted need of medical treatment by citizens on a low-income level, a need supposedly illustrated by rejection of 50 per cent of draftees, and the fact that state systems have been in operation in European and Asiatic countries.

To this last argument Dr. Eugene S. Kilgore replied that even though European and Asiatic countries had state systems of sickness insurance, American standards of health topped the world.—Boston, Mass., *Christian Science Monitor*, August 7.

* * *

Compulsion Threats

The shelving of compulsory health insurance in the California legislature without this year's bill even coming to a vote evidences afresh the recession of public interest. Among the states, the proposed system has made its largest bid in California. Four years ago, however, it was beaten 46 to 24 in the Assembly and two years ago 48 to 20. This year the plan was tabled by a Senate committee, and in the Assembly it was not even voted upon by committee, so far as the records show.

The movement for compulsory health insurance in the United States has in fact been declining ever since President Roosevelt put aside enabling legislation eighteen months ago. The immense cost officially estimated as at least $2,500,000,000 a year for national coverage, the huge

new taxes, the drawbacks of the bureaucratic medical service, the hostility of the organized medical profession, the advent of voluntary health insurance—plus the war—have combined against the project. Fortunately, the country has so far escaped being rushed into a mammoth insurance venture through popular ignorance of its failings.—Visalia *Times-Delta*, August 14.

COMMITTEE ON PUBLIC HEALTH EDUCATION†

Basic Science Initiative

Since publication of the August issue of California and Western Medicine, additional consideration has been given by the Committee on Public Health Education to the matter of distributing initiative petition forms for the Basic Science Law.

The first few petitions were distributed in Orange County and in the Lassen-Plumas-Modoc area, principally for the purpose of securing experience on the problems encountered by physicians and dentists in approaching the public for petition signatures. A meeting of interested physicians and dentists was held in Anaheim, Orange County, on August 11, at which time the experiences of petition circulators were recounted and the problems of the circulators discussed.

Following this meeting, the Committee has determined to distribute petition forms in a series of selected areas throughout the state, rather than attempting to make one state-wide distribution. As the petitions are mailed to physicians and dentists in each area, meetings will be held to answer the questions which are commonly asked by petition circulators and to start the circulators off on the right foot in their efforts to gather the 212,117 required valid signatures.

This change in program may mean that in some particular counties the initiative petitions will not be received for another two or three weeks. When the forms are sent to each section, however, the mailing will be backed up by a meeting for the discussion of all problems to be encountered.

It is most important that every California Medical Association member who circulates an initiative petition be fully advised as to the mechanics of circulation. Errors which are permitted to creep into the petition forms may very well invalidate the signatures secured. For this reason we are printing here a series of affirmative and negative instructions, designed to give at a glance the major features of the formal instructions. Each petition form will carry on its reverse side a complete list of instructions; the condensed list printed here is proposed to be bound into the petition form as a reminder to the circulator to read carefully the formal legal list of instructions:

* * *

Warning!

Please Read Carefully

Do

—Read and understand the instructions on the back of this petition *before* attempting to secure *any* signatures.

—Secure signatures *only* from registered voters in *your own* county.

—Require every signer to use pen or indelible pencil and fill out *every item* of Instruction 7 (on the back hereof) in his or her own handwriting.

—Start securing signatures just as soon as you are familiar with the instructions and return this petition fully completed within two weeks' time.

Do Not

—Permit any other person to circulate your petition after you have started it. You must make an affidavit that you personally secured all signatures. Additional petitions will be sent to you for your secretary or associates upon request.

—Put anything in the last column marked "Precinct."

—Permit signers to use ditto marks. These will invalidate the signature.

—Change, erase, or add to any signature.

—Secure even one signature until you have carefully read and fully understand *all* instructions. (Printed on back of petition.)

—Delay this important work. This petition should be completed and returned to The Public Health League within two weeks' time.

* * *

Read the instructions on the back hereof and follow them in every detail, or your petition may not be valid.

County Fair Committees

The placement of exhibits and presentation of public health films at county fairs, under the auspices of component county medical societies, was taken up after approval had been given at the last annual session of the California Medical Association at Del Monte, May 5-8, 1941.

The local committees in charge of arrangements include the following:

Tehama County Fair—June 12-14, 1941. F. L. Doane (chairman) and R. I. Thompson, both of Red Bluff.

Placer County Fair—June 20-22, 1941. J. A. Russell (chairman), Auburn.

Alameda County Fair—July 3-12, 1941. C. W. Mack (chairman), Paul Dolan, F. L. Herrick, Chesley Bush, all of Livermore.

Sonoma County Fair—August 2-9, 1941. W. C. Shipley (chairman), J. A. Fowlie, W. E. Rogers, all of Santa Rosa.

Humboldt County Fair—August 12-17, 1941. Morris Krutchkoff (chairman), Ferndale; Fred Olsen, Fortuna; and Joseph Brown, Eureka.

Stanislaus District Fair—August 11-16, 1941. Marion Collins (chairman), Turlock; Warren Steele and Robert Radcliff, both of Modesto.

San Joaquin County Fair—August 16-24, 1941. C. A. Broaddus, Stockton.

California State Fair (Sacramento)—August 29 to September 7, 1941. Dudley Saeltzer (chairman), Arthur C. Huntley, Walter M. Campbell, John G. Walsh, all of Sacramento.

Siskiyou County Fair—August 30 to September 1, 1941. V. W. Hart (chairman), Yreka.

Los Angeles County Fair—September 12-28, 1941. Paul A. Quaintance (Chairman), Wallace Dodge, Arthur E. Smith, all of Los Angeles.

San Mateo County Fair—September 18-21, 1941. Edward Schultze, San Mateo.

Merced County Fair—September 24-28, 1941. Chester A. Moyle (chairman), E. M. Soderstrom, and E. E. Willison, all of Merced.

Monterey County Fair—September 25-28, 1941. John C. Sharp (chairman), Salinas; Charles A. Galligan and Harry R. Lusignan, both of Monterey.

† The Committee on Public Health Education was established through Substitute Resolution No. 6 at the Del Monte annual session, May 3, 1939.

The Committee on Public Health Education consists of Frank R. Makinson, chairman, Oakland; Philip K. Gilman, secretary, San Francisco; Samuel Ayres, Jr., Los Angeles; Thomas A. Card, Riverside; James F. Doughty, Tracy; Lowell S. Goin, Los Angeles; Junius B. Harris, Sacramento; Henry S. Rogers (ex officio), Petaluma. Communications to the committee may be addressed to Frank R. Makinson, M. D., chairman, Wakefield Building, Oakland, or to the California Medical Association office, 450 Sutter Street, San Francisco.

San Diego County Fair—October 4-12, 1941. J. I. Knott (chairman), R. O. Logsdon, and T. J. O'Connell, all of San Diego.

Santa Clara County Fair—October 4-12, 1941. D. R. Threllfall (chairman), R. S. Kneeshaw, and J. H. Shephard, all of San Jose.

Ventura County Fair—October 8-12, 1941. Frank Gallison (chairman), Ventura; D. G. Clark, Santa Paula; Harry Barker, Ventura; and R. K. Harker, Oxnard.

Santa Cruz County Fair—October 16-19, 1941. Daniel D. Smith, Watsonville.

Encouraging reports have been received concerning the publicity attained at fairs that have been given. Letters requesting coöperation were sent to the presidents and secretaries of all component county societies. The roster of county fairs, with dates and other information, appeared in the July issue (page 46). Every component society should have a county fair committee. The coöperation of all members is urged.

Educational Display Shown by Medics at Humboldt County Fair

For the first time Humboldt County Medical Society has an educational display at the Humboldt County Fair at Ferndale. The exhibits belong to the American Medical Association and were prepared for New York and San Francisco World's Fairs.

The California Medical Association is sending them around to county and district fairs in an attempt to familiarize the public with medical progress.

In addition to the displays, daily showings of movies are given. Some of the films shown are: "In Defense of the Nation" (a tactful film on the menace of venereal disease), "Behind the Shadows" (a story of the fight against tuberculosis), "I Choose to Live" (modern methods for the cure of cancer), "Good-bye, Mr. Germ," and "On the Firing Line."

County nurses, on duty at the fair all day to answer visitors' questions, report public interest is gratifying.—Eureka *Standard*, August 14.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Arrangements for Refresher and Postgraduate Conferences

Officers of component county societies and their Program or Special Committees on Postgraduate Conferences are urged to communicate with the Association Secretary, Doctor Kress, regarding arrangements for postgraduate or refresher conferences, to be held during the fall and winter months. The California Medical Association Committee on Postgraduate Activities invites correspondence and hopes to be of increasing service in this important work.

* * *

International Assembly

Interstate Postgraduate Medical Association of North America

This year's international assembly of the Interstate Postgraduate Medical Association of North America will be held in the public auditorium, Minneapolis, Minnesota, October 13, 14, 15, 16, and 17.

The Hennepin County Medical Society will be host to the Assembly and has arranged an excellent list of Committees, who will function throughout the Assembly.

The officers of the Interstate Postgraduate Medical Association, those of the Hennepin County Medical Society and the Minnesota State Medical Association, extend a very cordial invitation to all members of the profession in good standing to attend the Assembly.

The members of the profession are urged to bring their ladies with them, as a very excellent program is being arranged for their benefit by the Ladies' Committee.

A full program of scientific and clinical sessions will take place each day and evening of the Assembly, starting at eight o'clock in the morning.

In coöperation with the Hennepin County Medical Society, the Minnesota State Medical Association, and the Minneapolis Civic and Commerce Association, a most excellent opportunity for an intensive week of postgraduate medical instruction is offered by in the neighborhood of eighty-five distinguished teachers and clinicians from different parts of the United States and Canada, who are honoring the Assembly by contributing to the program. The speakers and subjects have been carefully selected by the Program Committee.

Pre-assembly and post-assembly clinics will be conducted, free of charge, in the Minneapolis hospitals on the Saturdays previous to, and following the Assembly, for visiting members of the profession.

Excellent scientific and commercial exhibits of great interest to the medical profession will be an important part of the Assembly. These exhibits will be open to members of the medical profession in good standing without paying the registration fee.

The registration fee for the scientific and clinical sessions will be $5.

Members of the profession who can possibly arrange to attend the Assembly cannot afford to miss it.

The list of distinguished teachers and clinicians who are to take part on the program and whose names appear in the announcement, is placed in the advertising section of this JOURNAL. (Advertising index appears on page 8.)

For additional information, address Dr. William B. Peck, Managing Director, Freeport, Illinois.

* * *

Academy of Ophthalmology and Otolaryngology Meets in Chicago on October 19-23, 1941

The forty-sixth annual meeting of the American Academy of Ophthalmology and Otolaryngology will be held at the Palmer House, Chicago, October 19-23, under the presidency of Dr. Frank R. Spencer, Boulder, Colorado. Information may be secured by addressing American Academy of Ophthalmology and Otolaryngology, 1500 Medical Arts Building, Omaha Nebraska.

The Academy's program consists of one general scientific meeting on the morning of the first day, separate programs for the two specialties on alternate afternoons, and instructional courses every morning, beginning on Tuesday. . . .

Alternating with the scientific programs of the specialties each afternoon will be an elaborate motion-picture program. Thus, when the Section on Ophthalmology is meeting for formal presentation of papers, motion pictures on otolaryngology will be available for those interested in that field.

* * *

Anatomy Courses

The following letter, sent out by the Wayne County Medical Society (Detroit), indicates the extent to which the medical school in that city is coöperating in presenting facilities for follow-up courses in anatomy:

To the Members, Wayne County Medical Society.

Dear Doctor:

Courses in anatomy, to be given at Wayne University College of Medicine, begin in three weeks. Registrations are being taken now, and due to the limitation of the number that can be accommodated, applications will be honored in the order in which they are received.

Full details were carried in the *Detroit Medical News* of July 14, 1941. If you desire another copy, call the headquarters office, Temple 1-6400.

The general schedule is as follows:

Section I—Back, Thorax, and Abdomen, September 10 to November 26, 1941.

Section II—Pelvis, December 3 to 31, 1941.

Section III—Extremities, January 7 to March 11, 1942.

Section IV—Head and Neck, March 18 to June 3, 1942.

Register Now! For any or all of the four sections. Use this letter and form as an application blank, accompanied with a minimum deposit of $10.

Fees: $25 for any one section.
$45 for any two sections.
$55 for any three sections.
$60 for all four sections.

†Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

Please enroll me in the course (s) checked above.
Enclosed is $————
Doctor ————————
Please print.
Address ————————

(Make check payable to the Wayne County Medical Society, and mail to 4421 Woodward Avenue, Detroit.)

ADVISORY COUNCIL, CONTINUATION SCHOOL OF WAYNE COUNTY.

By Ralph H. Pino, M. D., *Chairman.*

Professor C. E. A. Winslow of Yale Available for Conferences

(COPY)

UNIVERSITY OF CALIFORNIA
EXTENSION DIVISION
BERKELEY, CALIFORNIA

August 20, 1941.

To the Editor:—We are sending herewith for your information a statement regarding Dr. C. E. A. Winslow, who is to be Rosenberg Professor in the Public Social Services at the University of California, Berkeley, during the fall semester, 1941.

Doctor Winslow, who will arrive in Berkeley the latter part of August, will be available without fee for a limited number of lectures and conferences throughout the state during the fall semester. He has expressed a willingness to speak to interested groups on the following subjects:

1. Public Health Yesterday, Today, and Tomorrow.
2. Health Problems of Defense.
3. The Air-Cooled Human Body. (The physiological bases of heating and ventilation.)
4. Problems of Mental Health.
5. Housing and Health.
6. Medical Care in Modern Society.

Requests for Doctor Winslow to speak and to take part in conferences will be filled as his time allows. Please address communications to the University Extension, 301 California Hall, Berkeley.

Sincerely yours,
(Signed) BOYD B. RAKESTRAW,
Assistant Director.

* * *

(COPY)

UNIVERSITY OF CALIFORNIA
DEPARTMENT OF SOCIAL WELFARE

August 4, 1941.

Dr. C. E. A. Winslow, Professor of Public Health at Yale University and one of the outstanding experts on public health in the United States has been appointed Rosenberg Lecturer in the Public Social Services at the University of California for the fall semester of 1941. Doctor Winslow will arrive in Berkeley late in August and will remain until the end of December. He will give two courses under the auspices of the Department of Social Welfare, one for undergraduates and one for graduate students, and will offer a lecture series open to the general public. In addition, it is expected that he will travel throughout the state to speak to various interested groups. . . .

Doctor Winslow's published writings are extensive. Among his books are "Nursing and Nursing Education in the United States," 1923; "The Laws of Health and How to Teach Them," 1925; "The Road to Health," 1929; "Health on the Farm and in the Village," 1931; and "The City Set on a Hill," 1934. In addition, he has written many articles and reports which have been published in leading journals or by government agencies.

Doctor Winslow has received high recognition, both national and international, as a health authority. He is a past president of the Association of American Bacteriologists and the American Public Health Association. He was general medical director of the League of Red Cross Societies, Geneva, in 1921, and was an expert assessor of the Health Committee of the League of Nations from 1927 to 1930. In 1929-1930 he was International Health Director of the Rockefeller Foundation.

The Rosenberg Lectureship which Doctor Winslow will hold in Berkeley was established two years ago by the Rosenberg Foundation of San Francisco for the purpose of bringing to the University of California for one semester at a time outstanding authorities on the public social services. Preceding lecturers have been Dr. Andrija Stampar, formerly director of health in Jugoslavia, and Miss Catherine Bauer of the United States Housing Authority. While in Berkeley, the visiting lecturers are attached to the staff of the Department of Social Welfare.

COMMITTEE ON HOSPITALS, DISPENSARIES AND CLINICS

Doctors Ask Hospitalization for Workers

Seeking to forestall an asserted bed shortage in private hospitals of Kings County, the Kings County Medical Association yesterday requested the Board of Supervisors to admit to the county hospital all Leemore air-base workers in need of hospital emergency treatment.

A delegation of medical men, headed by Dr. W. F. Chamlee, told the Board workmen injured or who became sick during the course of construction at the air base could be admitted as "insurance cases," if the Board was willing. Insurance companies would pay $4.50 per day for the men's hospitalization.

Included in the group, in addition to Chamlee, were Doctors J. A. Crawshaw, C. T. Rosson, Sr., and Paul R. Murphy. Doctor Rosson told the Supervisors there would be an influx of approximately four hundred laborers of various kinds to work on the air base.

Chairman of the Board, S. E. Railsback, asked how the delegation proposed to justify the potential approval of the Association's request to the taxpayers, in view of the fact that a small group of more or less transient workers would be thus entitled to hospitalization services that other county citizens were not.

Supervisor Russell Troutner pointed out that American Federation of Labor leader Ralph Averett had assured the populace that none but Kings County residents were to be hired as workers on the air-base project, which, if true, would make them bona fide Kings County taxpayers and as such entitled to the hospital's benefits.—Hanford *Sentinel,* July 23.

* * *

Protest on Handling of Indigent Sick

Direct result of protests by San Francisco doctors over the method of handling medical relief cases, a meeting has been ordered to decide just how the indigent sick of the city shall be treated, whether in a central relief clinic or by various hospital clinics.

The meeting was proposed today in a letter by Florence McAuliffe, president of the County Welfare Commission. The Commission ordered that action yesterday when it received from Dr. Harold A. Fletcher, president of the County Medical Society, a letter rapping city officials for failure to set up a central medical clinic for relief clients.

Invited to attend and help find a solution will be the County Medical Society; Dr. J. C. Geiger, county health director; representatives of the various clinics and of the Welfare Commission.

Doctor Fletcher said in his letter that the city has relied too much on the generosity of endowed and private institutions.

"San Francisco must face the facts of relief medicine," he said. "It cannot expect these institutions to carry a caseload of the size carried by the Central Medical Bureau under the SRA."

Doctor Fletcher offered the assistance of the Society to the city, saying, "The County Medical Society believes that the medical profession should be consulted in these special problems which its experience and training equip it to solve."

F. S. Durie, spokesman for the San Francisco Hospital Conference, said, however, that clinics actually are not pressed in care of these patients. Clinics are "ready, willing, and able" to assume relief clinic responsibility, he stressed.

But he admitted there has been complaint to the county about the sum paid for this treatment. County welfare officials said they have had formal request from the clinics to increase the payment per clinic visit, which now is set at 65 cents. Actual cost to the clinics is near twice that amount, Mr. Durie said.

"We aren't protesting, exactly, but our clinics do feel the cost of this service we handle for relief clients can be worked out more fairly, in a partnership spirit."

Meanwhile, distribution was being made by the state of supplies and equipment which composed the Central Medical

Bureau at the State Relief Administration office here. This bureau cared for a large proportion of the relief clients without sending them to hospital clinics. Its discontinuance when SRA was ended greatly increased the medical burden to local clinics.—San Francisco *News*, August 13.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (6)

Alameda County (4)

Elenore Erickson, *Berkeley*
L. K. Garron, *Oakland*
Gordon W. Richmond, *Oakland*
John R. Steinmetz, *San Leandro*

Kings County (1)

Allan E. Stamler, *Corcoran*

San Diego County (1)

Richard O. Peck, *San Diego*

Transfers (1)

W. O. Stadel, from Merced County to Alameda County.

In Memoriam

Dunsmoor, Nannie Cecilia. Died at Los Angeles, July 19, 1941, age 80. Graduate of University of Southern California School of Medicine, Los Angeles, 1900. Licensed in California in 1900. Doctor Dunsmoor was a retired member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Kaysen, Ralph. Died at La Jolla, August 4, 1941, age 56. Graduate of Milwaukee Medical College, Wisconsin, 1907. Licensed in California in 1928. Doctor Kaysen was a member of the San Diego County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Parrish, George. Died at Los Angeles, August 7, 1941, age 69. Graduate of Missouri Medical College, St. Louis, 1894. Licensed in California in 1924. Doctor Parrish was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✝

Strietmann, William Hurley. Died at Piedmont, July 14, 1941, age 60. Graduate of Medical College of Ohio, Cincinnati, 1905. Licensed in California in 1912. Doctor Strietmann was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

OBITUARIES

William H. Strietmann

1880–1941

On July 14, 1941, the community of the East Bay was profoundly shocked by the sudden demise of Dr. William H. Strietmann, stricken in his office. Two hours later he expired.

Doctor Strietmann received his degree of Doctor of Medicine from the University of Cincinnati in 1905, and served his interneship in the Good Samaritan Hospital in 1905 to 1906. Inspired by an urge for the ultimate in medical knowledge, he engaged in studies at the Postgraduate School of the University of Vienna.

He was assistant professor in physiology and bacteriology in the University of Cincinnati (1907-1911).

He came to Oakland in 1912 and it was not long before his inherent qualities led to high honor. He filled the post of Professor of Medicine in the Oakland College of Medicine (1913-1918). He became president of the Alameda County Medical Society in 1922; vice-president of the California Medical Association in 1923; chief of medical staff in the Highland Hospital in 1919 to 1941; and member of the Alameda County Institutions Commission from 1937 to 1941.

Geniality with keenness of intellect is a combination encountered too rarely. In him it was a magnet that drew to him an ever-increasing number of friends. Fairness and justice, tempered with tolerance, were conspicuous among his many attributes. His was an analytical mind, his reasoning always consistent, his views liberal. His code of professional ethics was sound, but never was his judgment perverted by a too rigid interpretation. Differences of opinion in consultation were always bridged by a graciousness and complete mutual understanding.

In the later years of his life he became an ardent enthusiast in the art of painting. With little instruction and much patience he became highly skilled and was given recognition by the critics as a painter of no mean ability. His pictures depict more than the subject portrayed, for in their quiet softness one sees the gentleness of character and the fineness of human instincts that guided him.

His memory will ever live in the minds of those who knew him. The influence of his doctrines and of his ideals will not be erased by time.

J. Louis Lohse
Edward N. Ewer
P. N. Jacobson
Committee

✝

George Parrish
1872–1941

Guardian of Los Angeles' public health for approximately fifteen years, and recognized as one of the outstanding sanitation experts in the country, Dr. George Parrish, City Health Officer of Los Angeles, died suddenly on August 7.

Death came after an abdominal operation performed August 4, which was followed by a heart attack.

Practical city officials pointed out the fact that during the fifteen-year régime of Doctor Parrish the health busi-

† For roster of officers of component county medical societies, see page 4 in front advertising section.

ness of the city of Los Angeles was conducted at an average annual cost to the taxpayers of but 50 cents per capita, while at the same time the community was largely free of epidemic disease and had a lower death rate than most metropolitan centers.

Often the center of stormy municipal political scenes, Doctor Parrish, nevertheless, was credited by both friends and enemies as one who not only had a thorough knowledge of his work, but always was ready to fight for the adoption of public health measures he considered necessary.

Remembered are his campaigns for compulsory examination of food handlers, household sanitation, and drives against rats and other infectious pests.

Although he had many friends, he also had many political opponents. First appointed health officer in December, 1924, he kept the position until 1931, when a municipal political upheaval saw him ousted from the job. He was reappointed in February, 1934, however, and served continuously thereafter until his death.

The son of Dr. John George Parrish, originally of Virginia, Dr. George Parrish was born in St. Louis on April 27, 1872. There he attended the public schools and later was graduated from Washington University, where he studied medicine.

After graduation the young doctor entered the St. Louis Health Department, where he served five years. In the early part of 1917 he became Health Commissioner of Portland, Oregon, and remained in that capacity until late in 1924. During the same three years, he also served as professor of public health and preventive medicine at the University of Oregon Medical School. He also was consultant at various Portland public institutions and hospitals, and was made president of the Oregon State Health Officers' Society.

The death of Dr. Luther M. Powers in Los Angeles left open the position of health officer here and Doctor Parrish was appointed to the post by former Mayor George Cryer on December 23, 1924. From that time on he watched the tremendous growth of the city and met its many urgent and complex sanitation problems. His department grew from a handful of employees to a staff of more than three hundred, serving more than a million persons.

The Los Angeles *Examiner* on August 9 printed the following editorial comment under the caption, *Death Robs City of Efficient Official:*

The death of Dr. George Parrish, City Health Officer, has deprived Los Angeles not only of a valuable and efficient public servant, but of a colorful and vigorous personality.

Doctor Parrish began his career as a private physician, but was quickly attracted by the then unexplored and primitive field of public health.

It was characteristic of the man that he preferred the difficult social problems of administrative medicine to its more lucrative and less irksome private practice.

He was singularly fitted for his chosen task.

He had the energy, the wider outlook, the general knowledge, and the executive capacity.

And he had another quality that brought him to high rank—an outspoken, uncompromising vigor that helped him overcome the inevitable frictions that are inherent to public office.

Under his régime many reforms and improvements were made in the official guardianship of municipal health.

Many times he risked his political safety by refusing to yield on scientific questions.

Many times, also, he used his political skill to bring about reforms once considered Utopian and now taken for granted as necessities.

Eulogies are quickly forgotten. But to say that Doctor Parrish left a city much healthier, more efficient in its hygienic conduct than when he came to it, is to say something that transcends impressive monuments.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. HARRY O. HUND.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM.....Asst. Chairman on Publicity

President's Report and Letter

On the Nineteenth Annual Convention of the Woman's Auxiliary to the American Medical Association, Held on June 2-6, 1941, at Cleveland, Ohio

Dear Auxiliary Members:

The nineteenth annual convention of the Woman's Auxiliary to the American Medical Association was held in Cleveland, Ohio, from June 2 to 6, 1941, where the Hotel Carter was the official headquarters.

The registration desks, the exhibits, and all the rooms for meetings were situated on the mezzanine floor, making a very compact unit.

The Woman's Auxiliary to the Ohio State Medical Association should be highly commended for planning such a well-conducted convention. This Auxiliary has but recently been organized, and its members deserve double praise, as they never had had the experience of undertaking such a meeting.

The Registration Committee was on duty early and late, and the tables were so well arranged, both for registration and social events, that there was no confusion. So many activities were offered that the heads of those attending the Convention were in a whirl.

Before continuing with the Convention, I would like to say that I left California on May 27, and had the pleasure of meeting several of the doctors and their wives on the train. This is one of the fine phases of the Auxiliary—the friendships which are made with people away from one's own close circle of friends. Then, on the train out of Chicago, sitting next to me was the president of the Woman's Auxiliary of Oregon, Mrs. Charles E. Sears. Having so much in common, we were together the greater part of the time while in Cleveland. To make our Pacific Coast states complete, Mrs. G. E. Hoxie, President of the Woman's Auxiliary of Washington, also joined us.

At this time, I wish to state that the national president of the Woman's Auxiliary for 1941-1942 is Mrs. R. E. Mosiman of Washington, and the western Auxiliaries are very proud of this fact.

The first regular session of the Convention was held in the ballroom of the Hotel Carter, with the president, Mrs. V. E. Holcombe, presiding. Mrs. J. E. Purdy, President of the Ohio Auxiliary, delivered a splendid address of welcome. She gave a thumb-nail description of Cleveland, the Forest City, a city of parks, art, and drama. She also stated that the membership of the Ohio Auxiliary was 1,600 the first year. Mrs. C. C. Tomlinson made the response, praising both the State Auxiliary and Cleveland as a convention city.

It was reported that 921 had registered.

I shall not dwell at length on the reports which followed, but will mention only a few of their highlights.

Organization.—Mrs. Charles H. Werner reported that the Auxiliary had "gone over the top" in paid-up memberships by April 22. There were 26,567 members, with four states not yet reporting. The goal for the year had been set for 25,000. Forty states are organized.

† Reports of county chairmen of publicity should reach Mrs. Rossner Graham, Assistant Chairman of Publicity, 6101 Acacia, Oakland, by the tenth of the month previous to publication. Address of the Chairman of Publicity: Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

Hygeia.—Mrs. W. I. Wanninger reported. Despite increased attention to other activities and projects due to present conditions, there were as many subscriptions as last year. Many letters had been received from educators and other influential persons, stating that *Hygeia* had proved very helpful to them. Hundreds of copies had been distributed at health exhibits.

Legislation.—Mrs. A. A. Herold reported. It is the third year since the Auxiliary entered that field, and the future years will bear the fruit of these first years. Special emphasis was laid on the study of socialized medicine and the physician's part in the medical defense program. Reference material will be sent upon request.

Program.—Mrs. Walter F. Donaldson reported. The National Program Committee's slogan was, "Services Offered Involve Obligations." Stressed were cancer control and socialized medicine, to strive to serve and to revitalize the county auxiliaries.

Public Relations.—Mrs. Henry Raile reported. Public relations has widened its scope to almost international relations during 1940-1941, due to the aid the Medical Auxiliary members have given to agencies of relief. Practically all the counties are following through with the National public relations program, and they are advised to look to local needs.

Bulletin.—Mrs. H. E. Christenberry reported. She stressed the importance of subscribing to the *Bulletin*, the magazine issued quarterly by the Woman's Auxiliary to the American Medical Association. It is a great help to State officers and chairmen, as this is the one means that the National officers have of reaching the states.

Mrs. R. E. Mosiman, the National president-elect, was presented. She emphasized home defense and nutrition, and pointed out that we must be leaders in those fields. When hearing Mrs. Mosiman speak, one is impressed with the fact that she has great strength back of her quiet manner, and that she will lead the Auxiliary into wider fields and inspire all of us.

The speaker of the session was Miss Etta A. Creech, her topic being, *What Is Sound Health Education?* Health education should not apply alone to children, but also to adults. Do not generalize too much; people are individuals, there are no averages. It is a rapidly changing field, and health education must keep abreast of new facts. Managing one's own health satisfactorily is sound health education.

Upon adjournment, we attended a luncheon honoring the past presidents.

The second session was held in the ballroom on Wednesday morning, Mrs. V. E. Holcombe presiding. Two-minute reports by the state presidents were given, from which some new and constructive ideas were derived.

The new officers were installed with a beautiful ceremony, conducted by Mrs. Rogers N. Herbert. Although our own past state president, Mrs. A. E. Anderson, was not present, I am happy to report that she was elected second vice-president of the National Auxiliary. This office brings with it the duties of organization chairman of the western division. We are proud to have her on the National Board, and wish her much success.

The guest speaker was Dr. Helen A. Hunscher, her subject being, *Nutrition—Food for Fitness*, which was most interesting and informative. She said: "Use dietary plans to increase health and the housekeepers of the nation will be called to the colors. People must be taught to like and eat food that is needed; to select well, to prepare properly, and to eat joyously."

The final number of registrations was 1,337. National Board, 47; delegates, 148; alternates, 27; members, 548; guests, 567.

The postconvention Board meeting was held Thursday morning, Mrs. R. E. Mosiman, President, presiding. It was very instructive to hear the exchange of ideas of the members of the National Board. The results of this meeting and the reports of the chairmen will appear in the August issue of the *Bulletin*.

Now to turn to the social functions of the Convention, which were many and varied.

Upon arriving in Cleveland on Sunday, we were invited to a tea for the National Board members, honoring the president, Mrs. Holcombe. On Monday there was a luncheon at the Hotel Carter, following which came a sight-seeing trip of Cleveland. We stopped at the Airport, where the United and American Airlines give courtesy flights over the city, and many of the members availed themselves of the opportunity.

That evening a dinner was held at the Union Club, honoring the Board of Directors. Dr. Norman C. Yarian gave an illustrated talk on *Orchids*. The moving pictures of the flowers were most beautiful, and I do not think that I have ever seen so many orchids worn by any group as I did that evening. The florists' supply must have been quite depleted.

Tuesday noon there was a luncheon, honoring the past presidents. The guest speakers were Dr. Nathan B. Van Etten, President of the American Medical Association, and Dr. Morris Fishbein, Editor of *The Journal of the American Medical Association* and *Hygeia*. Doctor Van Etten advocated the centralization of all national health functions and the decentralization of health problems. The local Auxiliary should take care of the latter. He said that the Auxiliary is a new and powerful social agency, which can clean up miserable housing and better the nutritive value of foods. He stated that 95 per cent of the doctors are willing to help in the national emergency, and that forty thousand physicians will go into service. This will mean change and sacrifice. A common ground must be found to support the best interests of our country, and we must prepare to play our part in a new future; we must also be careful not to let down the standards of medical education. A five-year program has been planned. "The doctor and his wife will carry on to preserve the American way of life" were his closing words.

Doctor Fishbein praised the work which the Auxiliary has been doing, and spoke of the fact that the American Medical Association is attempting to assume leadership for scientific national nutrition and that the Auxiliary should help to make it effective.

After this luncheon there was a tour of the Cleveland Health Museum. I could not take this trip, as I attended the round-table discussion, "The New Year."

The Cleveland Health Center is unique in that it was the first permanent institution of its kind to be opened in America. It is sponsored by the Academy of Medicine of Cleveland, and has attracted national attention from health, civic, and industrial groups.

The annual luncheon was held on Wednesday. Greetings were extended by Dr. W. W. Bauer, Director of the Bureau of Health Education of the American Medical Association; the Advisory Council of the American Medical Association were introduced, and the Mayor of Cleveland gave a splendid talk.

Doctor Bauer spoke of the growing significance of the work of the Auxiliary, its greatest help being in the field of health education. He stressed public relations meetings to make women more health-conscious, and also to make a survey of women's health interests.

Dr. Frank H. Lahey, President-Elect of the American Medical Association, and the Honorable Hatton W. Summers of Texas, Chairman of the Judiciary Committee, House of Representatives, Washington, D. C., were the guest speakers. Mr. Summers' talk gave us a very tragic and distressing picture of the present time, with not much hope for the future. He said that America must be told the truth and be awakened to the gravity of the situation. His talk left us all in a very serious mood.

But the next evening, at the annual dinner for husbands and wives, this feeling was counteracted, and the reading

from "Poems for Penquins" by its author, Mr. J. S. Newman (Prof. Si. N. Tific), satirist, caused much merriment and laughter. The reception and ball in honor of the President of the American Medical Association followed this dinner, and was held at the Hotel Cleveland.

There was also a very interesting trip to the Cleveland Cultural Center in Wade Park, where we visited the Art Museum and heard a delightful organ recital.

There was a reception and musicale in the Allen Memorial Library, honoring Mrs. Holcombe and Mrs. Mosiman on Wednesday evening. We visited the Medical Museum, which is in the same building. It was instructive to see the few primitive instruments our first physicians had to work with, and to know the hardships they had to stand.

As I had to leave Cleveland for New York on Friday, I could not attend the social entertainments for that day. All the business sessions were over on Thursday.

The privilege and honor of being sent by you, the members of the Woman's Auxiliary to the California Medical Association, to the convention at Cleveland to represent your State, will never be forgotten by me, and I wish to express to you my sincere appreciation and thanks.

Sincerely yours,

(Signed) Mrs. Harry O. Hund,
President.

CALIFORNIA PHYSICIANS' SERVICE†

BENEFICIARY MEMBERSHIP*

September, 1939	1,220
March, 1940	9,322
September, 1940	17,398
March, 1941	24,107
July 31, 1941	29,623

During the month of April, 1941, out of a membership of 25,414, 4,615 patients were treated. This required a total of 26,740 units of professional service. Of these units, 60.1 per cent were for medical service; 18.6 per cent for surgical service; 17.4 per cent for x-ray and laboratory; and 3.9 per cent for refractions.

In comparing the April figures with a cumulative figure for 1940, it is noted that there has been an increase in surgical service. This is probably due to the appearance of the first cases of elective surgery; for example, herniae, tonsils, and nasal septums, which could not be taken care of under the California Physicians' Service contract until a year's waiting period had elapsed. Many persons who joined over a year ago are now availing themselves of this service.

X-ray and laboratory services remain approximately the same as our last year's average.

There has been a slight drop in the number of office calls during April. This figure shows a reduction of about 500, but this is offset by an increased number of hospital calls. We look forward to a further decrease in the number of office calls during the summer months. The curve on our experience charts for last year shows that we may expect a decrease in June, July, and August. Since these are the months in which our reserve for the winter is built up, it is hoped that the trend for March and April will continue through the next three or four months. Since office calls take the greatest proportion of the funds, any appreciable reduction in this figure is of advantage to California Physicians' Service.

The volume of office calls is an indication of the extent to which the fund is being used for treatment of chronic diseases. California Physicians' Service patients made over 11,000 visits to doctors during the month of April for treatment in connection with conditions which might be classed as chronic. This is reflected in the percentage of membership receiving treatment: In April of 1940, 15 per cent of the members were given service; in April, 1941, the percentage had risen to 18 per cent. Forty per cent of these cases had received care in previous months.

It is significant that in April of last year the unit cost per patient, per month, was 6.41. In April of 1941, the unit cost per patient was 5.18 units. This represents a decrease in cost per patient per month of 1.23 units. This decrease has been steady during the past year, and may be due to the accumulation of a considerable number of chronic cases which do not require extensive care.

Administrative costs in relation to income continue to show a steady decline. In March, 1941, the figure was 22 per cent and in April it was 20 per cent.

†Address: California Physicians' Service, 333 Pine Street, San Francisco. Telephone EXbrook 3211. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the Official Journal is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

* For special article in this issue concerning California Physicians' Service, see page 139.

* * *

Health Surety Plan Opposed

Members of the Commonwealth Club are overwhelmingly opposed to any program for inauguration by the Government of a compulsory health insurance program.

This was shown in results of a poll released recently on the question, *"Do you favor the establishment by the Government of a system of compulsory sickness insurance (health insurance)?"*

The vote was 871 to 491.

Ballots on the question were mailed to all of the Club's members, following a study by its Public Health section and publication of pro and con reports on the issue.

* * *

Stanislaus County Employees: Hospitalization Coverage

A group hospital insurance plan for Stanislaus County employees is being considered by the Board of Supervisors.

Under the program, monthly pay-roll deductions would be made of $1.34 for men and $1.92 for women. This would entitle the employee to various hospital and surgical benefits as well as accidental and dismemberment injuries.

Group Health Plan Described for Club

Medical Association Program Outlined

California physicians, surgeons, and hospitals have made tremendous strides in the last few years toward providing complete medical and hospital care for families in the lower income groups, L. M. Cole yesterday told members of the Santa Monica Kiwanis Club.

Describing as "one of the most significant social developments of the last twenty-five years" the group medical service and hospitalization program sponsored by the California Medical Association, Cole declared that it provides unlimited medical protection at low cost for employed groups.

Not Socialized Medicine

"This is not socialized medicine," Cole said. "It is not compulsory; it is not subsidized by the Government; it is not operated for private profit."

Approximately 85 per cent of all doctors affiliated with the California Medical Association and 90 per cent of all California hospitals are qualified to treat patients enrolled under the group health care program, Cole said, and there is no limitation either upon the amount of care which may be given to one person during a year or the hospital and x-ray service.

One of the principal advantages of the plan, Cole said, is that it enables working people to obtain medical attention during the first stages of illness and thus tends to prevent the development of serious ailments.

Throughout the United States, the speaker said, the group medical care program now is serving 7,000,000 persons, the organization showing a 36 per cent membership gain last year.

The speaker was introduced to the Kiwanians by Dr. Fred G. Gruber, Santa Monica physician.—Santa Monica *Outlook*, August 13.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.†

California Medical Association, Hotel Del Monte, Del Monte, California, May 4-7, 1942.

American Medical Association, Atlantic City, June 8-12, 1942.

American Medical Association Meeting of State Medical Association Secretaries and Editors, 535 North Dearborn Street, Chicago, Friday and Saturday, November 21-22, 1941.

Forum on Allergy: Fourth Annual Conference, Detroit, Michigan, January 10-11, 1942.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of federal government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts.*

Los Angeles County Medical Association.

The following is the Los Angeles County Medical Association's broadcast schedule for the month of September, 1941:

Saturday, September 6—KFAC, 8:45 a. m., Your Doctor and You.

Saturday, September 6—KFI, 9:45 a. m., The Road of Health.

Saturday, September 13—KFAC, 8:45 a. m., Your Doctor and You.

Saturday, September 13—KFI, 9:45 a. m., The Road of Health.

Saturday, September 20—KFAC, 8:45 a. m., Your Doctor and You.

Saturday, September 20—KFI, 9:45 a. m., The Road of Health.

Saturday, September 27—KFAC, 8:45 a. m., Your Doctor and You.

Saturday, September 27—KFI, 9:45 a. m., The Road of Health.

Doctor Dukes Named to Commission.—Dr. Charles A. Dukes, prominent East Bay physician and surgeon of 211 The Uplands, Berkeley, was named a member of the Alameda County Institutions Commission, late yesterday by the Alameda County Board of Supervisors. His nomination was made by Supervisor Thomas E. Caldecott, also of Berkeley.

Doctor Dukes will fill the unexpired term of the late Dr. William S. Strietmann, who died earlier in the month. Doctor Dukes is vice-president of the American Medical Association.—Berkeley *Gazette*, July 31.

Two Siskiyou Boys Die of Plague from Flea Bites.—Yreka, Aug. 11.—County medical authorities announced today that the deaths of two young boys had been traced to sylvatic plague, described as a form of bubonic plague.

It was further announced that a drive is being organized to destroy all squirrels, chipmunks, rats, and mice within a five-mile radius of Shasta Valley and later to clear a similar radius around Yreka.

Dr. Albert Newton, public health officer of Siskiyou County, called Dr. Karl Meyer of San Francisco, noted specialist on bubonic plague, here to advise physicians of the county on preventive steps.

Doctor Meyer declared the present outbreak is not contagious—that is, it could not be contracted by association between human beings—but was carried by rodents and their fleas. Residents of the area were warned against contact with rodents.

The two victims were identified by Doctor Newton as Lee Bostmyer, five years old, of Mount Shasta, and Raymond Hart, ten, of Shasta Valley.

The Microfilm Service of the Army Medical Library. The Army Medical Library in Washington has recently inaugurated Microfilm Service for the benefit of physicians throughout the country, a microfilm being a strip of 35-mm. motion-picture film with images of printed pages photographed on it in sequence. By this method, any article in any one of the 4,034 current medical periodicals taken by the library can be obtained in microfilm copies at a very reasonable price. The charge is 30 cents for each complete article not exceeding thirty pages in length, and 10 cents for each succeeding ten pages or fraction thereof. Thus, an article can be obtained quickly for reading on a microfilm projector. This is particularly valuable for articles appearing in obscure and rare journals. Many of the small medical libraries do not take more than 200 or 300 current periodicals. The large libraries, such as the Boston Medical Library, take 800 or 900, but even this is small when compared with those taken at the Army Medical Library. The

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

films may be projected and read with a small hand projector; however, in most libraries, large machines are available which throw the pages on a screen two or three feet in size.

How does one find out about an article that is not likely to come to one's attention? To supplement the microfilm service, the Army Medical Library has added another of great importance to the medical profession. A weekly bulletin, *Current List of Medical Literature*, is published. Divided into large subjects, the literature of the week, as received in the Army Medical Library, is listed by the titles of articles occurring in medical periodicals. Thus, by watching one of the forty-four general classifications, a physician interested in keeping current with a special subject can quickly pick up references to that topic in any published periodical received by the library. The lists cover practically all the printed medical matter in the world. In many cases, of course, the periodical may be at hand in his own office or in his own medical library. In cases where this is not so, the Army Medical Library offers a solution for quickly bringing him the article in question. For the research worker, this brings medical literature to his desk almost immediately, three to six months before he could find it in an index, such as the *Quarterly Cumulative Index Medicus*.

Both these services are run by the Friends of the Army Medical Library. The library coöperated by providing the necessary space for the work, and by supplying the publications from which the microfilm copies are made. The only cost to the user is for actual labor and material required in making and distributing the microfilm copies. For the *Current List of Medical Literature*, a charge of $5 a year is made, which it is hoped will cover the cost of issuing this weekly bulletin. It should be pointed out, moreover, that occasionally, in addition to the current list of periodicals, a list of books received in a period of a month or six weeks at the Army Medical Library is also given to subscribers without additional charge.

Thus, the Army Medical Library, the largest and most efficient in the world, becomes a national medical library, serving the medical profession throughout the land. To many, such a course has long been a cherished ideal. With a new building in sight for the library, and with an expanding service, the medical profession should be appreciative of the fact that the Army Medical Library is alive to the present needs of the profession.

Many Refugee Doctors Come to America.—New York, July 28. American physicians, especially here in New York, are manifesting growing concern over the transfusion of foreign refugee doctors into the profession in this country. Already several thousand medical emigrés have been admitted to practice.

Native American doctors who are contemplating entering the country's armed forces in the medical service are apprehensive that their practices may be absorbed by foreigners during their absence. There are complaints of fee-cutting and other unethical acts by the recent European arrivals on file with county medical societies.

Last year 2,092 persons holding certificates from foreign universities (except Canadian) were examined by licensing boards in the various states, according to *The Journal of the American Medical Association*. Of this number, 1,429 applied for licenses in New York State.

Year by year the number of candidates from foreign institutions for licensure in the United States has increased.

By far the largest number of candidates come from Germany or countries under Nazi rule. Among the 2,092 applicants for 1940 were 1,378 from Germany or countries under Nazi rule. Among the 2,092 applicants for 1940 were 1,378 from Germany and of that number, 613 bore credentials from the University of Vienna.

Most liberal in admitting refugee physicians to examination and practice are the states of New York, Connecticut, Massachusetts, and Maryland, where first citizenship papers are virtually the only requirement.

Sixteen states, taking the position they are unable to evaluate foreign credentials because of the war abroad, do not admit holders of such certificates to examination. Nineteen states require full citizenship—which takes five years to achieve. Prerequisites in other states include basic science credits, internship in American hospitals, and work in United States approved medical schools. . . .

The problem of the refugee physician was a burning one at the recent convention of the American Medical Association, and the House of Delegates of the Medical Society of the State of New York presented a resolution asking that the practices of native American doctors and their hospital associations be protected while they are in military service.

Some American doctors are suggesting that the plea of President Roosevelt and the British Red Cross for one thousand physicians to volunteer for service in England be met by sending refugees.—Tempe, Arizona, *News*, July 29.

California Society for Crippled Children.—The California Society for Crippled Children and its county societies, in coöperation with the National Society for Crippled Children, announces the 1941 Area Institute for lay and professional friends of the crippled and disabled.

The purpose of the Area Institute is to inform the people of California of the services available for crippled children and physically handicapped persons, and how best to utilize these services.

The Institute is important to all professional groups and members of crippled children societies; crippled children, underprivileged and child welfare committees of service clubs; women's organizations, and fraternal orders; American Legion and its Auxiliary, Parent-Teacher Associations, and other organizations and interested individuals.

Further information may be secured from Warren E. Griffith, Executive Secretary, California Society for Crippled Children, 251 Kearny Street, San Francisco.

SCHEDULE

Tuesday, September 2—Weed, California

1:30 p. m., Grammar School Auditorium

Chairman: Mrs. L. L. Lichens, President, Siskiyou County Society for Crippled Children.

Introduction of Discussion Participants: Warren E. Griffith, Executive Secretary, California Society for Crippled Children.

Round-table session—Informal discussion from the floor. Counties included in this area meeting: Siskiyou, Shasta, and Trinity.

Thursday, September 4—San Francisco

1:30 p. m., Palace Hotel

Chairman: Mrs. T. E. Shucking, President, San Francisco Guild for Crippled Children.

Opening Address: Albert F. Roller, President, California Society for Crippled Children.

Round-table session—Informal discussion from the floor. Counties included in this area meeting: San Francisco. San Mateo, Santa Clara, Marin, Alameda, Contra Costa, Solano, San Joaquin, Monterey, Mendocino, and Sonoma.

Thursday, September 11—San Diego

12:10 p. m., San Diego Hotel

Luncheon meeting with San Diego Rotary Club.

1:45 p. m., Institute

Chairman: William H. Evans, President, Society for Crippled Children of San Diego County, Inc.

Introduction of Discussion Participants: Warren E. Griffith, Executive Secretary, California Society for Crippled Children.

Round-table session—Informal discussion from the floor.

Counties included in this area meeting: San Diego and Imperial.

Friday, September 12—Los Angeles

2 p. m., Biltmore Hotel, Music Room

Chairman: Lawrence L. Frank, President, Crippled Children's Society of Los Angeles County.

Opening Address: Albert F. Roller, President, California Society for Crippled Children.

Round-table session—Informal discussion from the floor.

All visitors to the Institute are welcome to attend the regular Rotary luncheon meeting at 12 noon in the Biltmore Hotel.

Counties included in this area meeting: Los Angeles, Orange, Riverside, San Bernardino, Kern, Ventura, and Santa Barbara.

Monday, September 15—Fresno

12:15 p. m., Hotel Californian

Luncheon meeting with Fresno Rotary Club.

1:45 p. m., Institute

Chairman: Mrs. Charles Winchell, President, Fresno County Society for Crippled Children.

Opening Address: Albert F. Roller, President, California Society for Crippled Children.

Round-table session—Informal discussion from the floor.

4:45 p. m.

Annual business session of the California Society for Crippled Children.

Reports of officers and committees.

Election of officers and members of the Executive Committee for 1941-1942.

All visitors to this Institute session are invited to remain for the business session, which will be very brief.

Counties included in this area meeting: Fresno, Madera, Tulare, Kings, Merced, and Stanislaus.

Los Angeles County Tuberculosis Sanatorium: Medical Director Sought.—Seeking an outstanding physician for an important position, the Los Angeles County Civil Service Commission has just announced an open competitive examination for medical director of the county tuberculosis sanatorium. The salary for the position is $500 a month and the usual three-year county residence requirement has been waived, thus allowing all qualified men who are United States citizens to participate in this examination.

In order to qualify to take the examination, men between the ages of 35 and 55 must have been graduated from an approved medical school with a degree of M. D. and have had at least five years' experience as a specialist in the treatment of tuberculosis. Of the five years' experience, three or more must have been in a responsible administrative and executive capacity in a sanatorium or hospital.

Application blanks and additional information regarding the position can be obtained from the office of the Civil Service Commission, Room 102, County Hall of Records, Los Angeles, California. Applications must be filed with the Commission by Wednesday, October 15.

Olive View Sanatorium is located in the foothills of the San Fernando Valley, approximately twenty-five miles from the center of the city of Los Angeles. In addition to 1,150 patients at the Sanatorium, 300 patients are housed in a sanatorium camp at Acton, California, and 100 patients are housed in private institutions by contract with the county. Medical care and treatment of all patients are under the direction of the Medical Director of Olive View Sanatorium.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Four County Medical Societies Hold Meeting in Vallejo

The Solano County Medical Association this week was host to more than 159 physicians of Napa, Sonoma, and Marin counties, and newspapermen, state senators and assemblymen, and city and county officials of those and other districts at a dinner in the Vallejo Country Club, held on Tuesday, July 22.

It was the annual meeting of the physicians of the four counties, and was presided over by Dr. John W. Green, general chairman and toastmaster. Doctor Green is councilor for the Ninth District of the California Medical Association. More than one hundred of those present are practicing physicians, coming to Vallejo from Sacramento, Oakland, San Francisco, Burlingame, and as far south as Fresno.

Regular business of the Association was not considered. The entire evening was taken up by a banquet, entertainment, and brief talks from several of the distinguished guests.

Dr. H. L. Rogers, President of the California State Medical Association, was among those present. Accompanying him was George H. Kress of San Francisco, State Secretary of the Association, Executive Secretary Hunton of Los Angeles and Hartley Peart of San Francisco, attorney for the Association.

Other guests included Captain R. G. Davis, executive officer at the Naval Hospital, Mare Island; Captain J. R. Holman, Captain George W. Shepard, navy yard medical officer, and approximately fifteen other officers.

Guests from out of the city present were Assemblyman Roger Pfaff of Los Angeles, State Senator Thomas Keating of Marin County; Senator Herbert Slater of Sonoma; Senator Frank Gordon of Napa; Senator Thomas McCormack of Rio Vista; Assemblyman Ernest Crowley of Suisun; Senator Tony DeLappe of Richmond; Assemblyman Richard McCollister of Sonoma and Marin counties; Superior Judge Hillard Comstock, Santa Rosa; Superior Judge Butler of Sutter County. Superior Judge W. T. O'Donnell of Solano County and Superior Judge Percy King of Napa were unable to attend, being away on annual vacation.

Newspapermen and publishers of the various districts were headed by Publishers Luther E. Gibson and Robert L. Jones of Vallejo. Among other guests were members of the Board of Supervisors and other county and city officials.

Arrangements for the affair were directed by Doctors H. Brownlie Perkins, Carlton Purviance, and H. R. Madeley.—Rio Vista *News*, July 24.

* * *

Health Bureau Savings Urged

Councilman Roy Hampton suggested yesterday that Los Angeles avail itself of a State law and save $500,000 a year by contracting to have the County Health Department take over the work of the City Health Department.

Shortly before introduction of the resolution, President Maurice Sparling of the City Health Commission visited the Council and introduced Dr. George M. Uhl, recently appointed city health officer, pending a civil service examination.

Hampton's resolution proposes that the Bureau of Budget and Efficiency make a survey and analysis of the situation, reporting its findings to the Council.

Hampton said city taxpayers provide 58 per cent of the operating expenses of the County Health Department, for which they receive very little in return. He cited instances where city, county, and state health men make parallel inspections of dairies, packing plants and the like.

His resolution was approved unanimously.—Los Angeles *Times*, August 13.

* * *

Social Security Board Is Somewhat Inconsistent

Arthur J. Altmeyer, chairman of the Social Security Board, told a congressional committee the other day that our Social Security program should be broadened.

The nation, he said, should have a system of health insurance, pensions for the totally and permanently disabled, and wider participation by the Federal Government in state welfare programs.

But is this the time to undertake such a program?

The country is faced with staggering bills for the defense program, bills which may be tripled, quadrupled, or worse, before we are out of the woods of the uncertain and steadily deteriorating international situation.

To carry out the Altmeyer program would superimpose additional millions and perhaps billions on the federal budget. It simply is not within the limits of what can be attempted at this time. . . .—Sacramento *Bee*, July 26.

* * *

Catholic Women Told to Fight Birth Control

New York, August 19 (AP).—Delegates to the convention of the National Catholic Women's Union were told today that "our present-day marriage is, in many instances, a cloak for immorality."

The Rev. Hubert Beller of St. Gerard's Maternity Guild of the New York branch of the National Catholic Women's Union, urged his hearers to meet the challenge of birth control and declared:

"There are 2,000,000 fewer children in the public schools today than there were a decade ago. Fully 60 per cent of the families in the United States have either no children at all, or only one or two.

"One marriage out of six ends in divorce. Fifty per cent of the persons who become divorced have no children and a further 25 per cent have only one child per family."—San Francisco *Chronicle*, August 20.

United States Population Decline Start Predicted in 1980

Decline in the population of the United States may be expected to start shortly after 1980, according to United States census forecasts.

The increase in the population, which has been steady since the founding of the nation, by 1970 will be less than 1.2 per cent, as compared with the increase of 7.2 per cent revealed in the 1940 census.

Birth Rate Dropping

The estimates were prepared by the National Resources Planning Board, Warren S. Thompson and P. K. Whepton of the Scripps Foundation for Population Research.

Indications are of a falling off in the birth rate.

At the same time there will be a steady increase in the number of persons of 75 years of age and older.

In 1940, for example, persons four years old or less numbered 10,597,891. In this same group by the year 1980 there will be only 9,301,000.

In 1940, persons 75 years old, or older, totaled 2,607,432. By 1980 this group will be nearly four times as great for a total of 7,796,000. In other words, fewer will be born, but those who see the light of day may expect to live to a ripe old age.

Folks Will Grow Older

Persons less than four years old now comprise 8 per cent of the nation's total popu'ation. By 1980 they will form only 6.1 per cent.

On the other hand, those 75 and older who now comprise only 2 per cent of the population, will have advanced to become 5.1 per cent.

The largest age group as disclosed by the 1940 census was composed of male and female persons between the ages of 15 and 19 years.

'Teen Age Group to Decline

Those of the 'teen age are now 9.4 per cent of the total population. But in 1980 they will drop to but 6.6 per cent to be replaced by the 30 to 34 years group which will by then become 6.9 per cent, or the leading group of the nation.

The interesting figures have been compiled without consideration of possible changes in the immigration laws.—Pasadena *Star-News*, July 29.

* * *

Sterilization "Curbs Crime"

Compulsory military service for youths of 18, and voluntary sterilization of criminals were urged today by Dr. Leo L. Stanley, chief surgeon at San Quentin, as "two measures which, in a feeble way, might aid in crime prevention."

A year's military service, he told the American Prison Association Convention at the Fairmont Hotel "would provide an excellent opportunity for completely examining, mentally as well as physically, all young men."

"Should it be determined a youth were mentally ill, he could be institutionalized and properly treated," said Doctor Stanley. "Twenty per cent of all criminals in prisons are feeble-minded. Had this been determined when they were only 18 or 19, proper steps could have been taken to care for many of these cases before they reached prison."

He warmly defended voluntary sterilization, which was denounced earlier during the convention by the Rev. George O'Meara, San Quentin chaplain.

"Sterilization is a simple operation, requiring only about fifteen minutes," said Doctor Stanley. "None of the man's normal functions is impaired except the reproduction of his own kind.

"Stockmen employ sterilization to keep their herds pure. Orchardists eliminate infected trees. Gardeners pull up weeds. Why shouldn't we use the same procedure for the human race, particularly the criminals, to prevent them from producing offspring that might inherit the bad qualities of the parents? This is effectively done in insane asylums, where proper legislation allows it to be carried out."

Instead of attempting compulsory sterilization, said Dr. Stanley, the medical departments at California prisons "have resorted to persuasion, leaving the decision to the inmate himself."

During the past seven years, he said, 600 prisoners have submitted to such operations. Most of the men, he added, were in prison for crimes involving property, and not sex. . . .— San Francisco *News*, August 21.

* * *

Sing Sing Doctor Attacks Methods; Cays Most Convicts Are Mentally Sick

Science through the lips of a Sing Sing doctor coldly indicted the American prison system as one hundred years behind the times—"in that state where mental hospitals were when they were called lunatic asylums."

Dr. Ralph S. Banay, psychiatrist in charge of classification at New York's Sing Sing, ripped to shreds the popular notion of crime and punishment.

In his studies of Sing Sing prisoners, he said, only 31 per cent could be classified as normal persons. The remainder range from the alcoholic to the insane. All should be treated in hospitals.

In an interview and before the night sessions of the American Prison Congress in the Hotel Fairmont, Doctor Banay declared punishment, in most cases, is an expensive and ineffectual process.

Yet it is essentially the philosophy of prison.

Little Improvement

The 70 per cent of prison inmates who drift through the prison routine are released with little improvement, Doctor Banay said.

"With this large percentage of those whose mental health is in great need of care and attention, prisons are still proceeding along primarily custodial lines."

Prisons, built to punish and to hold the offender from society, he added, "are inadequate to meet the real need of the inmate and warrant enough safety to society for the readjustment of the individual offender upon release from the prison.

"Even the best and all-inclusive program would result in correction sterility unless the mind of the individual is prepared to absorb and assimilate it."

This is the mental health of men received at Sing Sing, according to statistics of ten years:

One per cent is insane; 11 per cent are mental defectives; 20 per cent are alcoholics; 20 per cent are immature and of the split personality type.

"Inmates who were not found mentally ill were far from possessing good mental health," Doctor Banay said. . . .

Mental Deficiencies

Fourteen per cent of Sing Sing prisoners (figures are probably true in all prisons, he said) are mentally deficient. The mental age is sometimes as low as six years old.

They need special care since they cannot understand and follow through a prison routine based on the normal mentality. They are unclean, indolent, morose, sullen. They flare up emotionally. They start fights.

But these are not the real problem. Psychopathic states, alcoholics, the emotionally immature, and others of the abnormal need something other than prison.

One out of five, Doctor Banay found, is emotionally immature.

"These men could commit crime of the most atrocious nature. They expose themselves to hazards and risks, feeling no fear prior to nor satisfaction after performance of the crime. . . .

Alcoholics

Alcoholics, 20 of the 70 per cent, "cover up an underlying condition. They don't drink for pleasure. They are driven by an uncontrollable urge and should be in other institutions."

The same is true of cases of sex pathology, which Doctor Banay believes are compulsory. He said such men are of normal intelligence, but are unable to help themselves.

Prison fails to do anything for them, he said.

Instability of mood sends a seemingly normal man to writing checks or charging bills, and the emotional swing may take him back to despair and suicide. . . .—San Francisco *Chronicle*, August 22.

LETTERS†

Concerning New Provisions and Instructions Regarding California Narcotic Laws.

STATE OF CALIFORNIA
DEPARTMENT OF PENOLOGY
DIVISION OF NARCOTIC ENFORCEMENT

San Francisco, August 20, 1941.

George H. Kress, M. D., Secretary
California Medical Association
San Francisco, California

Dear Doctor Kress:

At the last session of the State Legislature, I recommended certain changes in the Health and Safety Code of California, particularly dealing with our regulations on habit-forming drugs.

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† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

After almost one year of the use of the official triplicate form of narcotic prescriptions, we found that we could make certain changes that would remove from the official forms some drugs that were not habit-forming, in the dosage usually prescribed by the doctors. Effective September 13, 1941, Ethyl-Morphine, commonly known as Dionin, Lead and Opium Wash, Apomorphine, Stokes Expectorant, Brown's Mixture, Syrup of Cocillana Compound, and all other preparations containing not more than two grains of opium to the fluid or avoirdupois ounce, will be written on the old form of prescription, and not on the official triplicate blanks. Straight Codeine (tablet or powder form) and Tincture of Opii Camphorated (Paregoric) when not compounded with other ingredients will be written on the official blanks.

We were requested by the chiropodists to broaden the provisions of our narcotic laws to permit approximately one hundred of their members to purchase narcotics on the Federal Order Forms and to prescribe drugs commonly used for external treatment of the feet. After the effective date of the new law, the chiropodists will be entitled to the use of those drugs that are necessary in their practice.

For several years past there has been a need for emergency supplies of narcotics in many of our small private institutions, and Section 11331.5 of the Code was amended in order to permit an emergency supply in hospitals which do not employ a resident pharmacist and which hospitals are under the supervision of a licensed physician. This supply may be purchased by the superintendent, a licensed physician, on his Federal Order Form and administered by a registered nurse or nurses under his direction. The prevalence of automobile accidents in the remote sections of our State where narcotics were needed for immediate use necessitated this change in our law. The fact that narcotics were not immediately available caused unnecessary suffering to the injured while the supply was being ordered from some other source.

Enclosed herewith please find a draft of the sections as amended in the Health and Safety Code relative to habit-forming drugs.

I would sincerely appreciate your courtesy in publicizing these new regulations to the members of the medical profession through the California and Western Medicine journal.

(Signed) Paul E. Madden,
Chief, Division of Narcotic Enforcement.

* * *

(COPY)

Division of Narcotic Enforcement
State of California
Paul E. Madden, Chief

New Legislation Pertaining to Issuing Narcotic Prescriptions

Effective September 13, 1941

Instructions to Those Authorized to Issue Prescriptions for Narcotic Drugs in the State of California

In the last session of the State Legislature (fifty-fourth session, 1941), that part of Division X of the Health and Safety Code which pertains to the writing of narcotic prescriptions was amended in the following particulars:

Section 11166.12 of the Code was amended to read as follows:

The provisions of this code, with reference to the writing of narcotic prescriptions on official triplicate blanks and the filling thereof, do not apply to any preparations containing codeine or to preparations containing not more than two grains of opium to the fluid or avoirdupois ounce, without additional narcotics when compounded with other medicinal ingredients or to preparations containing apomorphine hydrochloride, or ethylmorphine hydrochloride (dionin), prescribed in writing in good faith for medicinal purposes only.

When codeine, or tincture opii camphorata (paregoric) is not compounded with other ingredients, it shall be prescribed on the official blanks.

Section 11200 of the Code was amended to read as follows:

The provisions of this division requiring prescriptions and physicians' reports do not apply to preparations or to remedies or prescriptions sold or prescribed in good faith for medicinal purposes only and not for the purpose of satisfying addiction, containing not more than one grain of codeine in one fluidounce without additional narcotics, or not more than ten grains of chloralhydrate in one fluidounce, or two grains of cannabis sativa in one fluidounce, or, if a solid preparation, in one ounce avoirdupois.

Section 11331.5 of the Code was amended to read as follows:

In order to provide a supply of narcotics as may be necessary to handle emergency cases, any hospital which does not employ a resident pharmacist and which is under the supervision of a licensed physician, may purchase narcotics on Federal order forms for said institution, under the name of said licensed physician, said supply to be made available to a registered nurse for administration to patients in emergency cases, upon direction of a licensed physician.

A report showing the kind and amount of narcotics purchased on the Federal order form shall be forwarded, by registered mail, to the Division of Narcotic Enforcement, at the time such narcotics are purchased.

In all other respects the law, of course, remains the same as heretofore.

Physicians specializing in conditions of the eye, ear and nose, please note the first amendment referred to—that of Section 11166.12, with reference to Dionin.

All physicians should note the preparations which do not require the triplicate form of blank. The Narcotic Division has been receiving a great number of prescriptions which do not require the triplicate form. This only adds to the work of the Division as well as the prescriber and the druggist.

Relative to the drugs and preparations referred to under Section 11166.12: It will be noted that the drugs and preparations therein included are not to be prescribed on the triplicate narcotic prescription blank. *However, a regular prescription blank must be used when prescribing such drugs and preparations.*

Copies of the Narcotic Act will be furnished by the Narcotic Division upon request. For information address:

San Francisco office, 156 State Building. Telephone, UNderhill 8700.

Los Angeles office, 102 State Building. Telephone, Mutual 3804.

Concerning Address of G. W. Crile, M. D., to Humboldt County Medical Society.

To the Editor:—The Humboldt County Medical Society held a special dinner for Dr. G. W. Crile on Saturday night, August 2, 1941. Doctor Crile, Mrs. Crile, and his associates, Dr. D. B. Quaring and Mr. James Barrett, attended. Doctors Crile and Quaring gave a review of their book, "Intelligence, Power, and Personality," to be published in September, 1941.

They dissected and studied the organs of four whales in Eureka. This was the culmination of fourteen of effort in which time nearly four thousand animals from mouse to the whale were dissected. The relationship between the sizes of different animals, their degree of activity and their organs were explained. Their studies were mainly with the brain, thyroid gland, and celiac ganglion.

The talk was given in easily understandable language, and all those present were inspired by the personality of Doctor Crile. Our society feels indeed fortunate in being afforded the opportunity to act as host for Doctor Crile and his associates.

Sincerely yours,
(Signed) J. S. Woolford, M. D.,
Secretary.

Concerning Trichinelliasis.

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

San Francisco, August 14, 1941.

To the Editor:—Attached is a copy of a news release, "Trichinelliasis in San Francisco," which I thought would be of interest.

101 Grove Street.

Sincerely,
(Signed) J. C. GEIGER, M. D.,
Director.

* * *

(COPY)

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

August 13, 1941.

City Editor
San Francisco, California

Dear Sir:

Trichinelliasis in San Francisco
Classification of Food Involved

For the twelve and one-half year period 1929 to August 1, 1941, inclusive, there were 275 cases of human trichinelliasis reported to the Department of Public Health in San Francisco. In tracing down the sources of the disease in respect to the alleged food involved, it is interesting to note that the survey shows the following:

Food	*Cases*
Pork sausage	61
Salami	54
Fresh pork	40
Mettwurst	30
Ground pork and meat loaf	11
Raw pork	6
Pork chops or steaks	6
Ham	4
Home-cured salami	3
Raw pork sausage	1

Other foods noted included imported sausage, head cheese, mixed Chinese food, pickled pork, raw bacon, smoked pork, and thirteen cases in which the food was unknown. Of unusual interest was the reporting of seven cases in which the food causing the trichinelliasis was bear meat.

In 1934, of the thirty cases of trichinelliasis reported, many were traced to salami. A rigid control system with additional control measures was instituted in November, 1934, for the preparation and sale of salami. Other active control regulations inaugurated at this time by the San Francisco Department of Public Health were as follows:

1. The regulation which requires retail butcher shops, kitchens of hotels and restaurants to display a placard stressing the warning that *All Pork Must Be Cooked Thoroughly.*
2. The enforcement of higher standards of sanitation on hog ranches supplying local abbattoirs.
3. The elimination from the local market of substandard hog ranches.
4. A laboratory check on fresh pork entering the San Francisco abattoirs.

Beginning with 1935, the number of cases of trichinelliasis reported was as follows:

	Cases
1935	31
1936	18
1937	9
1938	19
1939	3
1940	8
1941 (to August 1)	4

This was in definite contrast to the cases reported for the six years preceding 1935, when there were 184. It could be considered, therefore, that improvement has been made in the attempt to eradicate trichinelliasis in San Francisco.

This survey has demonstrated some of the difficulties involved in obtaining specimens of food for laboratory analysis where trichinelliasis is suspected. Of the 275 cases reported for the period 1929 to August 1, 1941, inclusive, laboratory examination of the food involved was obtained only in twenty-two cases. Diagnosis in many cases was by clinical findings and examination of the patient's blood for further confirmation.

SUMMARY AND CONCLUSIONS

Certain basic essentials stand out in any control program for eliminating trichinelliasis, namely:

(*a*) Cooking of garbage swill a sufficient length of time before feeding to hogs.

(*b*) Control of rats on hog ranches.

(*c*) Cooking of all pork *well* and particularly small cocktail sausages.

(*d*) Proper processing (San Francisco method) of salami.

Since the inauguration of additional rigid control measures in processing salami in 1934, no cases of trichinelliasis attributed to local commercially prepared salami have been reported.

Sincerely,
(Signed) J. C. GEIGER, M.D.,
Director.

Concerning Costs of Hereditary Taint of Chorea.

To the Editor:—Huntington's chorea is a disease recommended by the American Neurological Association for inclusion in any sterilization program. One-half of the children of chorea patients will develop the disease, the other half will be carriers and transmit the disease to their children.

In the seventeenth century there were two people in the Massachusetts colony known to be afflicted with Huntington's chorea. Two hundred years later a report on the study of the family history of that couple disclosed that there had been located 962 descendants of the original couple who had been confined in institutions suffering from the same disease. How many more had been confined and not located, and how many not confined, is not known. Nine hundred and sixty-two descendants from one couple in two hundred years is a sufficient burden on society and taxpayers.

Had the original couple been sterilized the expense to the taxpayer would have been saved, as well as the misery and suffering to those individuals and their families. Who wants to be born into the world a degenerate? Who wants degenerates in their family who would have nothing but a drab, dreary, and miserable existence before them?

Those who pose as friends to these unfortunates and oppose eugenics sterilization are mistaken in their judgment. The best friends of sterilization are those who have had degenerates in their own families. An intelligent study of the subject wins supporters.

EUGENE H. PITTS, M. D.
—Sacramento *Union*, July 31.

Concerning Treatment of Disease by Nurses or Teachers.

In an opinion prepared at the request of the California Board of Medical Examiners, under date of July 10, 1941, Attorney-General Earl Warren, Thomas Coakley, Deputy, provides a clear statement of the limitations that the law places upon nurses and teachers in the provision of treatment and diagnosis of disease. The opinion follows:

"Your request of recent date propounds the following questions:

1. Is it legal for teachers or nurses while being paid for their services as such to give treatments other than the first one to students or others for boils, warts, carbuncles, cuts, lacerations, moles, abrasions, contusions, or sprains?
2. Is it legal for nurses or teachers while employed as such to diagnose diseases, and/or placard or quarantine cases without a licensed practitioner's prior diagnosis?

3. Is it legal for a doctor of medicine to delegate authority to teachers or nurses employed as such or others for pay or without pay to diagnose diseases or give treatments for patients not under his immediate supervision?

Preliminarily, it should be noted that the practice of the healing arts is limited to persons duly licensed under the various laws of the state regulating the several types of practice or systems of treating the sick and afflicted. Anyone who diagnoses or treats another without possessing a license to employ the particular type or mode of treatment used in the particular case is guilty of a misdemeanor. (Business and Professions Code Section 2141; also opinion NS3128.)

The exceptions to the foregoing are (*a*) emergency treatment which may be rendered by anyone, including teachers or nurses (Business and Professions Code, Section 2144), and (*b*) nursing service rendered under the supervision and direction of a person licensed to practice one or more of the healing arts.

In answer to your first question, I find no authority by which a teacher or nurse may *treat* for any injury or disease, except under the circumstances described in (*a*) and (*b*) above. I might add that I am unable to perceive how, for example, treatment for a wart or mole could be considered emergency treatment. To come within the exceptions noted, the emergency must be bona fide.

Your second question is, likewise, answered in the negative.

As pointed out in the beginning of this opinion, Business and Professions Code, Section 2141, makes it unlawful for anyone not licensed as a physician, drugless practitioner, chiropodist, or midwife to *diagnose* the mental or physical condition of another. Under the established principle of law that statutes on the same general subject, called statutes *in pari materia,* must be read and construed together, we must add to the foregoing list of persons who may lawfully diagnose conditions coming within the authorized scope of their practice or treatment, licensed naturopaths, osteopaths, chiropractors, and dentists. (See 23 Cal. Jur., p. 785; also opinion NS3128.) All persons not licensed to practice one of the modes of treating the sick and afflicted, mentioned in this paragraph, who diagnose diseases, do so in violation of Business and Professions Code, Section 2141, and thereby commit misdemeanors. Teachers and nurses, not being so licensed, may not diagnose. Nor do I find any statute authorizing a teacher or nurse to placard or quarantine premises or persons in the absence of a diagnosis by a licensed practitioner of the existence of a quarantinable disease.

Your third question is, likewise, answered in the negative.

Only licensed practitioners may diagnose or treat. (Business and Professions Code, Section 2141.) The privilege or right to practice a particular healing art is a purely personal privilege or right on the part of those who possess the prescribed qualifications, have met the prescribed requirements, and to whom a license has been issued by the duly authorized state agency. It is a privilege or right which cannot be delegated to another not similarly licensed. This principle is given express recognition in Business and Professions Code, Section 2392, which reads, in part, as follows:

. . . the aiding or abetting of any unlicensed person to practice any system or mode of treating the sick or afflicted constitutes unprofessional conduct within the meaning of this chapter.

This does not, however, prohibit a licensed practitioner, in treating pupils, from using the services of a nurse, acting under his supervision and direction.

The only doubt that may be cast upon the foregoing conclusions to be found in the School Code, Division 1, Chapter 4, Sections 1.110-1.127. However, upon careful analysis, I am of the opinion that there is nothing in said Chapter 4 in conflict with the principles above announced.

Said Chapter 4 provides for supervision of the health of pupils by 'physical inspectors' who may be either a physician, teacher, nurse, oculist, dentist, optometrist, or any one or more of such persons (School Code, Section 1.110), and provided such person holds a health and development certificate issued pursuant to the School Code (School Code, Section 1.112).

Said chapter further provides, by implication if not expressly, that such physical inspectors shall examine pupils as to their physical condition and note any defect that may exist (School Code, Section 1.120), reporting same to the parent or guardian to take action to cure said defect. (School Code, Section 1.123.) Said chapter also provides for the giving of sight and hearing tests by physical inspectors. (School Code, Section 1.120a.) Finally, the chapter provides that the pupil shall be sent home 'whenever there is good reason to believe that such child is suffering from a recognized contagious or infectious disease.' (School Code, Section 1.121.)

Nowhere in said Chapter 4 is there any express or implied authorization given the physical inspector to *treat* any pupil.

Nowhere in said Chapter 4 is the term 'diagnose' used. With reference to the possibility of an implied authorization to diagnose, I do not believe that the Legislature used the term 'examine,' or the term 'testing' of sight and hearing, or the phrases 'any defect noted by the physical inspector' or 'good reason to believe that such child is suffering from a recognized contagious or infectious disease' in the sense of a professional diagnosis as used in and prohibited by Business and Professions Code, Section 2141 (discussed *supra*). It is my opinion that said terms and phrases were employed by the Legislature in the sense of an observation by a person trained in a general way to note certain readily recognizable characteristics or symptoms of disease or defects and to report thereon to the parent or guardian or to the school authorities, as required under the circumstances of the particular case.

Any other construction would conflict with Business and Professions Code, Section 2141, prohibiting the diagnosing and treating by unlicensed persons. By construing Chapter 4 of Division 1 of the School Code in the manner above indicated, the provisions of said School Code and of the Business and Professions Code, respectively, are reconciled and each given efficacy. The rule is well established that such construction must be accorded wherever possible. (23 Cal. Jur., p. 192.)

Very truly yours,

EARL WARREN, *Attorney-General.*

By Thomas Coakley, *Deputy.*"

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.

San Francisco

Socialized Medicine: Is the Word "Insurance" Misused?

Recent discussions in the JOURNAL* concerning the use of the terms "health insurance" or "sickness insurance" to describe payment for medical and surgical services by means of fixed periodic payments, has moved us to add our views on proper terminology.

Our quarrel is with the indiscriminate use of the word "insurance," a label which does not fit except in a few instances. As descriptive phrases have tremendous propa-

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

* In August CALIFORNIA AND WESTERN MEDICINE, see page 107.

ganda value and are capable of affecting the thought of the entire population, we feel justified in submitting a brief analysis of the term "insurance" as applied to medical services. For the effect upon thinking of a descriptive phrase, consider what would probably happen to life insurance companies if life insurance were universally described as "death insurance."

The word "insurance" has been defined by countless authorities, sometimes in terms sufficiently broad to include all contracts regardless of subject matter, and at other times in narrow terms including only those contracts involving an assumption of another's risk and an agreement to identify the other person for any loss caused by the risk in return for a consideration or "premium." Statutes, judicial decisions, dictionaries, and textbooks usually agree upon a definition in substance as follows:

> An agreement under which the insurer, for a consideration, agrees to reimburse or indemnify the insured against loss or damage caused by the happening of a contingent or unknown event.

Before applying the foregoing definition to medical services, it must be determined whether the cost of medical care is or is not a "contingent or unknown event." It must also be determined whether or not payment for medical services is a "loss or damage."

Clearly, the time of need for medical services is unpredictable. Accordingly, the event is contingent and we may conclude that if the *cost* of such services is a "loss or damage" that insurance is involved in those instances where the cost is indemnified or reimbursed.

With respect to "loss or damage," it is highly debatable whether the cost of medical services is the type of *loss* contemplated by insurance statutes. Merely because an event is costly does not mean that it involves loss or damage. Taxes are costly. Food and lodging are costly. The acquisition and maintenance of an automobile is costly. Yet no one would contend that an individual's necessary expenditures for food, lodging, clothes, and transportation involve loss or damage. Such expenditures are a part of the matter of living. On the other hand, if one's house burns down or one's ship sinks or the head of the family dies, there is a catastrophe which may be said to be a loss or damage. As between these two kinds of costly occurrences, where should we classify medical and dental and other health services? It seems to us that they they are a part of everyday living and that their cost falls within the same category as food, lodging, and clothing. If this is so, then the cost of such services is not a loss or damage in the sense of a catastrophe arising from a contingent or unknown event. Hence, the word "insurance" is never properly used to describe a means adopted for the payment of medical services.

However, let us assume that the cost of medical services can be said to be a loss or damage so that the word "insurance" may properly be used to describe certain functions. If so, the word can only be used in those instances where the cost is indemnified or reimbursed *not* where the cost is absorbed by an outside agency—public or private—because, as we have seen, insurance inherently involves indemnification or reimbursement. Under this view, contracts calling for indemnification or reimbursement for medical and surgical costs actually incurred can properly be said to be insurance and can be defined as "sickness insurance" or "health and accident insurance," as the case may be.

Proceeding further, even with the concession that indemnification or reimbursement of medical costs is insurance, we still cannot use the word "insurance" to describe most socialized medicine plans. No governmental plan in operation or proposed involves reimbursement. On the contrary, such plans inevitably call for direct furnishing of *services* by the governmental entity, thus eliminating to the beneficiary any direct payment for medical services and substituting a periodic tax. The services furnished are secured either through employment of physicians or through the payment of fees by the Government for services rendered.

Most nongovernmental plans involve the furnishing of services by a lay entity in return for periodic payments. Here again the lay entity (by "lay entity" is meant any legal person, natural or artificial, including groups of physicians operating under a common name) either secures services through employment of physicians or through payment on a fee basis. In either instance, the beneficiary or patient is not indemnified or reimbursed for cost of services, but in lieu thereof receives a direct service in return for periodic contributions.

Governmental plans can only accurately be described as "state medicine," for they are exactly that, namely, the sovereign furnishing medical care. Most private plans can probably best be described as "coöperative medical service" or "group medical service." Those having limited panels furnishing service are merchandising a commodity—medical care—and should be so described. Those having open panels which permit a real freedom of choice are in fact *coöperative* endeavors between physicians and patients to solve a problem and should be so designated.

To describe sickness insurance, state medicine, and cooperative or group medical service in one all inclusive phrase is, we believe, impossible. Certainly neither health insurance nor sickness insurance is sufficiently broad to be a workable definition. Perhaps "socialized medicine" is the nearest that one can come to a definition that will include both indemnification of the cost of medical services and furnishing of medical services by a lay entity—governmental or private—in return for periodic contributions. Unless the medical profession is willing to become classified as one small subdivision within the field of insurance, it will do well to shun the word "insurance" in describing social experiments undertaken by it or imposed upon it except those that actually indemnify or reimburse the patient for professional bills incurred in the normal physician-patient relationship.

MEDICAL EPONYM

Jacksonian Epilepsy

This condition bears the name of John Hughlings Jackson (1834-1911). The following quotation was written by an anonymous contributor to the column, "Reports of Medical and Surgical Practice in the Hospitals of Great Britain," and appeared in the *British Medical Journal* (1:773,1875), under the title, "London Hospital: Clinical memoranda of a series of interesting cases of nerve disorder now in hospital (under the care of Doctor Hughlings Jackson). . . ."

". . . In the convulsions spoken of (commonly called epileptiform convulsions), a good deal occurs before the patient loses consciousness. One patient gave a very vivid account of what Dr. Hughlings Jackson calls the 'march of the spasm.' This patient's fit begins in his left index-finger and thumb; it then passes up the arm, and affects the face, and next passes down the leg. It is the rule that fits which begin in the hand should begin in the index-finger and thumb; when they begin in the foot, they usually begin in the great toe.

"Speaking of these cases, and with reference to their difference from such cases as are commonly called epilepsy par excellence, Dr. Hughlings Jackson said that he thought the abrupt division into cases with and cases without loss of consciousness was not even justifiable on grounds of convenience. . . . The distinction was, he insisted, into cases where consciousness was lost first of all, very early or late in the paroxysm.—R. W. B., in *New England Journal of Medicine*, Vol. 225, No. 4, July 24, 1941.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XIV, No. 9, September, 1916

From Some Editorial Notes:

Malpractice Indemnity Fund.—If a good many members who have expressed approval of the plan presented in the July *Journal*—whereby an indemnity fund is to be created, out of which fund any possible judgments or settlements in actions brought against contributors to the fund can be settled—do not act, the whole plan will fall. If you have not sent in your check for $15 and your note for a like amount payable one year after date, do so at once. Find your copy of the July *Journal* and read the details of the plan as therein presented. . . .

Program Committee.—The Committee on Scientific Program of the State Medical Society has met, organized, and laid out an excellent plan for the scientific program of the next session, which will be held at Coronado. Dr. A. B. Grosse of San Francisco was elected chairman, and Dr. R. A. Peers of Colfax, secretary. The president of the Society, Doctor Kress, has strongly recommended to the Program Committee that they require abstracts of the papers to be read to be in the hands of the Committee at least sixty days before the meeting. This will allow the abstracts to be published in the *Journal* of the month before the meeting, and permit those who are interested to attend and discuss the papers which principally attract their attention. . . .

Grievance Committee.—It will be recalled that when the agreement between the committee of the State Medical Society and the committee of the Underwriters' Board of Adjusters was presented for consideration by the Society two years ago, part of the plan included the formation of a joint committee which should consider complaints and recommend solutions. This committee was duly appointed some time ago and is known as the Grievance Committee. The first session of the committee was held early in August and a considerable amount of preliminary work was done. . . .

. . . The cases presented for consideration by the committee were, speaking generally, of two classes: (1) where the physician had padded his accounts; and (2) where the physician had a just account, but had not explained the circumstances to the insurance company. The insurance companies are perfectly willing to pay fees in excess of those specified in the fee schedule where the services given are unusual and extraordinary. . . .

In Support of Health Insurance.—A brief in support of health insurance prepared by the American Association for Labor Legislation and just issued from its New York headquarters gives in detail the facts which make health insurance legislation necessary in this country. The case for health insurance rests upon these fundamentals: the high sickness and death rates prevalent among American wage-earners; the need for more extended medical care; the necessity for a systematic method of meeting the wage loss due to sickness, and the need for further measures to prevent sickness. This situation, the report points out,

(Continued in Front Advertising Section, Page 26)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By Charles B. Pinkham, M. D.
Secretary-Treasurer

Board Proceedings

At a regular meeting of the Board of Medical Examiners held at Native Sons Hall, San Francisco, June 30 to July 3, there were approximately 163 applicants for written examination. They comprised physicians and surgeons, drugless practitioners, and chiropodists.

After hearings based upon charges of unprofessional conduct, the following changes in status of licentiates were made:

Oliver Roy Busch, M. D., charged with alleged illegal operation, found guilty on July 1, 1941. Imposition of penalty deferred to the October meeting of the Board.

Ammi Lloyd Johnson, M. D., charged with alleged narcotic dereliction. Certificate was revoked on July 1, 1941.

Howard Doane Mayers, M. D., charged with habitual intemperance, was on July 1, 1941, found guilty and ordered by the Board to surrender his medical certificate and not to practice in California until his certificate was restored to him. The Secretary was ordered to notify the County Clerk of the surrender of Doctor Mayer's certificate and that said certificate had not been revoked.

Alfred Edward Meyers, M. D., charged with alleged narcotic dereliction. Certificate was revoked on July 3, 1941.

Albert Henry Taylor, M. D., on July 3 stipulated that he would discontinue practice and surrender his certificate, whereupon the Board dropped further action.

Valina Trojan (Midwife), charged with alleged illegal operation. License revoked on July 1, 1941.

* * *

At the meeting held in Los Angeles, July 14 to 17, inclusive, 126 applicants wrote the examination for various classes of certificates, including physician and surgeon, drugless practitioner, and chiropody.

John E. Baker, M. D., whose license was revoked on March 10, 1938, had his California license restored on July 17, 1941, and was placed on probation for a period of five years.

Robert V. Baker, M. D., whose license was revoked on June 29, 1938, had his license restored on July 17, 1941.

Following hearing of the legal calendar, changes in status of the following licentiates were effected:

Aage E. Brix, M. D., charged with aiding and abetting, was found guilty on July 16, 1941, and placed on probation for a period of two years.

Edward Thomas Martin, M. D., charged with alleged narcotic dereliction, was on July 16, 1941, found guilty and placed on five years' probation, without narcotic privileges.

Alexander S. Waiss, M. D., on July 15, 1941, was found guilty of the charge of conviction of the Harrison Narcotic Act and was placed on two years' probation, without narcotic privileges.

News

"Dr. Thomas D. Wyatt was fined $40 Thursday morning by Judge R. P. Stimmel after he had entered a plea of guilty to charges of violating the state pharmacy code. Walter Thorpe and a 13-year-old boy, both clerks at the store, also appeared before the court, but charges against them were dismissed. Doctor Wyatt was accused of permitting the selling of drugs and medicines by other than registered pharmacists in the store. . . ." (Redding *Record*, July 17, 1941.)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

How to Use S-M-A Powder

EACH PACKAGE OF S-M-A* CONTAINS ONE MEASURING CUP

1 Empty one tightly packed measuring cup of S-M-A powder into bottle.

2 Add enough warm previously boiled water to make one ounce.

3 Cap bottle and shake powder into solution. Feed at body temperature.

4 Easy, isn't it?

S-M-A READY TO FEED PROVIDES:

● 20 calories to the ounce, but more important, the nutritional value of S-M-A is that of a complete well-balanced food. When prepared as above, each quart provides:

10 mg. Iron and Ammonium Citrate
200 I. U. of vitamin B_1
400 I. U. of vitamin D
7500 I. U. of vitamin A

NORMAL INFANTS RELISH S-M-A—DIGEST IT EASILY AND THRIVE ON IT

*S-M-A, a trade mark of S-M-A Corporation, for its brand of food especially prepared for infant feeding—derived from tuberculin-tested cow's milk, the fat of which is replaced by animal and vegetable fats, including biologically tested cod liver oil; with the addition of milk sugar and potassium chloride; altogether forming an antirachitic food. When diluted according to directions, it is essentially similar to human milk in percentages of protein, fat, carbohydrate and ash, in chemical constants of the fat and physical properties.

ACCEPTED AMERICAN MEDICAL ASSN

S. M. A. CORPORATION • 8100 McCORMICK BOULEVARD • CHICAGO, ILLINOIS

FROM PORTRAIT OF WILLIAM WITHERING, M.D.

WITHERING HEIGHTS

DIGIFOLINE, *"Ciba"* offers the physician a digitalis that may be said to reach the heights of Withering's therapy.

DIGIFOLINE *"Ciba"*

While disputes have raged as to the best method of standardization, Digifoline has not changed in rigidity of potency testing for many years. The physician can always be sure of this:—one tablet, one cc. of liquid, or one (2 cc.) ampule of Digifoline* is equivalent to one cat unit. To sum up: this digitalis preparation is uniform and Ciba is constantly on guard to maintain this high standard. No glycerine or alcohol is present in the ampules, thus eliminating any irritation produced by these substances.

Oral, intravenous, intramuscular or rectal administration in auricular fibrillation, congestive heart failure, loss of cardiac tone, etc.

*Trade Mark Reg. U. S. Pat. Off. Word "Digifoline" identifies the product as digitalis glucosides of Ciba's manufacture.

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PROFESSIONAL PROTECTION

SINCE 1899 SPECIALIZED SERVICE

A DOCTOR SAYS:

"This has been my first experience in ten years of licensed practice but it has been worth all the premiums I have paid to be able to go ahead with my work and let your Company do the worrying."

THE MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 26)

the Association concludes that compulsory health insurance alone offers the appropriate remedy. Moreover, health insurance contains possibilities for preventing illness not possessed by alternative forms of voluntary insurance. In the words of the report, "Compulsory health insurance is at once an economical method of providing for the needs of the wage worker and a mighty force for the inauguration of a comprehensive campaign for health conservation."

We cannot do better than to recommend a careful study of this brief to convince our readers that universal health insurance not only is inevitable but desirable, and that it behooves the medical profession of California to be prepared on this question.

Malpractice Rules.—Again must our members be warned to take particular notice of two very important rules made by the Society in regard to medical defense.

First, in all cases of fracture or injury to bones, joints and the like, an x-ray *plate* must be *made and kept*. The Society will not defend an action against a member arising out of such an accident or condition, where the member has not made *and kept* an x-ray *plate*, unless he offers a most satisfactory explanation of the reason why this was not done. During the last few years the *Journal* has repeatedly warned the members of the Society that the time is quickly coming when courts will hold that the not taking of an x-ray plate is negligence. It is safe to prophesy that, although no court has up to the time of writing made such a definite ruling, some supreme court will rule in that way within the next two or three years. Several decisions have come very close to announcing this doctrine. Recently two

(Continued on Page 32)

Q. I've heard that milk is a fine source of calcium. But what about canned milk?

A. Canned milk is an excellent source. In fact, canned milk, diluted with an equal amount of water, supplies the same amount of calcium and other minerals as whole, fresh milk. In addition, it is a valuable source of protein, fat and carbohydrate, vitamin A and the factor formerly designated as vitamin G (riboflavin). (1)

---

(1)
1940. Am. J. Pub. Health 30, 169.
1939. Food and Life, Yearbook of Agriculture, U. S. Dept. Agr., U. S. Government Printing Office, Washington, D. C., page 276.
1939. Accepted Foods and their Nutritional Significance, Council on Foods of the American Medical Association, Chicago, page 236.
1934. Am. J. Pub. Health 24, 194.

ACCEPTED Council on Foods AMERICAN MEDICAL ASSN.

The Seal of Acceptance denotes that the nutritional statements in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

AMERICAN CAN COMPANY
230 Park Avenue, New York, N. Y.

The "light" brew in a bottle of

ACME BEER

contains but 44 calories per 100 grams

IN THE *Science* OF DIETETICS

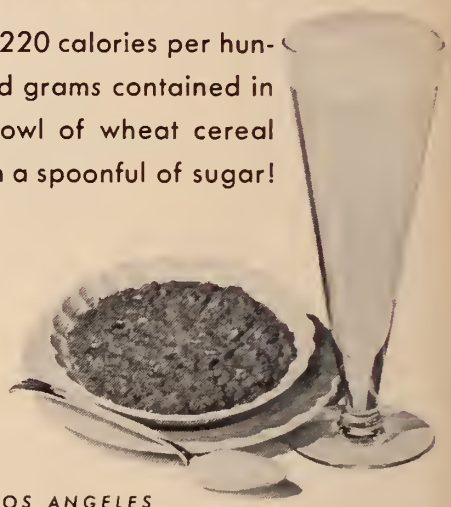
Those foods containing relatively few calories with respect to bulk, and which do not contain those factors which turn most readily to fat in the body, are considered non-fattening.

ACME BEER HAS FEWER CALORIES GRAM for GRAM THAN MOST FOODS!

Throughout the West modern men and women say "YES" to Acme Beer because it brings them delicious, satisfying refreshment and *is* "Dietetically NON-FATTENING!" Among such foods in normal diet as roast beef, bananas, and even melba toast, scientific analysis proves that Acme Beer contains fewer calories by far. It's skillful brewing of more costly ingredients that maintains Acme quality.

COMPARED TO

the 220 calories per hundred grams contained in a bowl of wheat cereal with a spoonful of sugar!



ACME BREWERIES • SAN FRANCISCO • LOS ANGELES

THE POTTENGER SANATORIUM AND CLINIC

For Diseases of the Chest — *Monrovia, California*

AN INSTITUTION FOR DIAGNOSIS AND THERAPY

CHOICE rooms and bungalows at rates ranging from $35 per week up, including medical service, general nursing, x-rays, routine laboratory examinations, ordinary medicines and therapeutic pneumothorax.

A few accommodations as low as $25 per week assigned on special application in selected cases.

In the foothills of the Sierra Madre Mountains, thirty-five miles from the ocean. Surrounded by beautiful gardens.

Close medical supervision. Aside from tuberculosis, special attention is given to asthma, bronchiectasis, lung abscess and kindred diseases.

For particulars address:

THE POTTENGER SANATORIUM AND CLINIC, Monrovia, California

BELMONT **Twin Pines** CALIFORNIA

Fatigue states, neuroses, and selected mental cases

ALLEN WILLIAMS, M. D.
Internal Medicine

Telephone BELMONT 111

WILL REBEC, M. D.
Psychiatry

TWENTY-FIVE YEARS AGO

(Continued from Page 30)

members have been obliged to defend two suits at their own expense because of failure to comply with this rule.

Second, the matter of suing for the collection of an account within one year after the services were rendered. The Society will not defend a cross-complaint arising out of such a suit for collection, unless the member who wishes to bring the suit presents the case to the Council of the State Society and receives permission from the Council to proceed. Within the last two months three members have been obliged to defend actions of this character against them at their own expense.

Suits for damages for alleged malpractice against physicians are steadily increasing, and no single week passes without such a suit arising; in one week quite recently,

(Continued on Page 34)

Symptomatic Control of Hay Fever and Asthma with . . . Propadrine Hydrochloride

How Supplied . . .

CAPSULES:	3/8 grain—bottles of 25, 100 and 500; 3/4 grain—bottles of 25, 100 and 500.
ELIXIR:	Each fluidounce contains 2 grs. 'Propadrine' Hydrochloride. In pints and gallons.
SOLUTION (Aqueous):	1% (isotonic)—1-ounce and pint bottles; 3%—1-ounce and pint bottles.
NASAL JELLY:	In 1/2-ounce tubes containing 0.66% 'Propadrine' Hydrochloride.

Sharp & Dohme

RAGWEED and other fall weeds now cast a shadow across the lives of countless thousands of "hay fever" victims.

In the symptomatic control of this allergic condition, 'Propadrine' Hydrochloride has been found particularly advantageous in providing immediate relief from annoying coryza and other vasomotor symptoms. It is therapeutically as effective as ephedrine and its pharmacological action is similar, but its advantages in the symptomatic control of hay fever and asthma are manifested particularly by:

1. **the comparative absence of side-effects such as insomnia, nervousness, ond excitation.**
2. **simultoneous odministrotion of sedatives is usually obviated.**
3. **may be odministered in therapeutic dosage over long periods of time.**

'Propadrine' Hydrochloride (phenyl-propanol-amine hydrochloride), because of its bronchodilator action, affords relief to many asthmatic patients when administered in 3/8-grain doses every three hours. This may be increased to 3/4 grain every three hours in adults and in children over eight years of age without untoward effect.

Solution 'Propadrine' Hydrochloride is also of value in allergic rhinitis with associated edema of the nasal mucous membrane, as it produces a rapid and sustained vasoconstricting effect on the engorged tissues.

VEGEX
for
B VITAMINS

A Pioneer Vitamin B Complex

DEPENDABLE AND ECONOMICAL FOR REGULAR USE

Vitamin research in nutrition and medicine discovered the high vitamin B complex potency of Vegex. Whatever the need or desire for high concentration, the natural vitamin B complex has not been concentrated into a more potent form than brewers yeast nor Vegex, the condensed autolyzed extract of brewers yeast.

Vegex is so easily borne that it is regularly prescribed for infants, in postoperative cases as well as for general vitamin B complex reinforcement. It is particularly useful in liquid or other restricted diets.

The tasty meatlike flavor of Vegex is best appreciated when it is used as directed—diluted and in small quantities. Vegex may be added to the diet in a variety of ways, a few of which are as follows:

Vegex Bouillon

From one-half to a level teaspoonful of Vegex to a cup of hot water or the water in which vegetables were cooked. Try adding a dash of lemon to Vegex bouillon and thoroughly chill.

Vegex-Tomato Juice Cocktail

Dissolve from one-half to a level teaspoonful of Vegex in a little warm water and add to a glass of chilled tomato juice.

Vegex-Butter

Cream together 1 part of Vegex with 10 or 12 parts of butter for sandwiches, toast or baked potato.

Samples and Literature Will Be Sent on Request

Vitamin Food Co., Inc.
122 Hudson Street

Vegex, Incorporated
New York, N. Y.

86c out of each $1.00 gross income used for members benefit

PHYSICIANS CASUALTY ASSOCIATION
PHYSICIANS HEALTH ASSOCIATION

Hospital, Accident, Sickness
INSURANCE

For ethical practitioners exclusively
(56,000 Policies in Force)

LIBERAL HOSPITAL EXPENSE COVERAGE	For $10.00 per year
$5.000.00 ACCIDENTAL DEATH $25.00 weekly indemnity, accident and sickness	For $32.00 per year
$10.000.00 ACCIDENTAL DEATH $50.00 weekly indemnity, accident and sickness	For $64.00 per year
$15.000.00 ACCIDENTAL DEATH $75.00 weekly indemnity, accident and sickness	For $96.00 per year

39 years under the same management
$2,000,000 INVESTED ASSETS
$10,000,000 PAID FOR CLAIMS
$200,000 deposited with State of Nebraska for protection of our members.

Disability need not be incurred in line of duty—benefits from the beginning day of disability.

Send for applications, Doctor, to
400 First National Bank Building • Omaha, Nebraska

TWENTY-FIVE YEARS AGO

(Continued from Page 32)

five suits were filed against members of this society. In view of this condition of things, it is imperative that our members take every precaution to prevent the possibility of suits arising, and to make it practicable to defend them when they do arise. It is frequently a very difficult thing to prepare the defense in some of these actions, and when this has to be done without complete records in the doctor's possession the task becomes very much more difficult.

From an Original Article on "The Removal of Foreign Bodies from the Esophagus and Respiratory Tract," by H. B. Graham, M. D., San Francisco.—I have had fourteen cases of foreign bodies removed by means of the esophagoscope or bronchoscope, four from the respiratory tract, and the rest from the esophagus. The number is not large when compared with the 388 which Jackson had done up to 1914, but our field is small and we must be content to learn from a smaller material. . . .

From an Original Article on "The History in Group Study (A Summary of One Hundred Case Histories)," by J. Marion Read, M. D., San Francisco.—This discussion will be confined to a study of one hundred case histories taken from the records of an organization for group study at St. Luke's Hospital. Throughout the process of differential diagnosis, this organization, by its system, aims at the control of dangerous omissions during the taking of clinical histories and the making of physical and laboratory examinations. . . .

. . . Conclusions: In conclusion, it should be stated that the slight scientific value possessed by so few statistics

(Continued on Page 36)

As an Adjunct in the Treatment of ALCOHOLISM

ONE of the newest and most interesting uses for which Benzedrine Sulfate has been accepted by the Council on Pharmacy and Chemistry of the A. M. A. is as an adjunct in the treatment of chronic alcoholism and also in alcoholic psychoses, although best results are reported in states of intoxication in which no psychosis is demonstrable. The articles listed below represent the most comprehensive work which has been done to date in this field.

Reifenstein, E. C. Jr. and Davidoff, E.: **The Treatment of Alcoholic Psychoses with Benzedrine Sulfate**—J. A. M. A., 110:1811, 1938.

Reifenstein, E. C. Jr. and Davidoff, E.: **The Use of Amphetamine (Benzedrine) Sulfate in Alcoholism With and Without Psychosis**—N. Y. State Med. J., 40:247, 1940.

Bloomberg, W.: **Treatment of Chronic Alcoholism with Amphetamine (Benzedrine) Sulfate**—New Eng. J. of Med., 220:129, 1939.[1]

[1] *Since this report, Bloomberg has enlarged his series to 60 cases which he reported on Dec. 28, 1940, at the annual meeting of the American Association for the Advancement of Science in Philadelphia. His results in this larger series were substantially the same as those in his original report.*

ADMINISTRATION

Initial dosage should be small (2.5 to 5 mg.) and should be increased progressively until the desired effect is obtained.

IN CHRONIC ALCOHOLISM

the normal dosage used by Bloomberg was 20 mg. daily, one-half of the dose on rising and the other half at noon, but this was often adjusted to meet the requirements of the individual patient.

IN ALCOHOLIC PSYCHOSES

the normal dosage used by Davidoff and Reifenstein in institutionalized patients was 20 to 30 mg. orally or intravenously* in a single dose.

IMPORTANT! In prescribing Benzedrine Sulfate Tablets, please be sure to specify the tablet-size desired—either *5 mg.* or *10 mg.*

*Physicians wishing to use Benzedrine Sulfate Ampules may obtain them on direct order from us.

Benzedrine Sulfate Tablets

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry

Brand of amphetamine sulfate

SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.

FRENCH HOSPITAL •

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CALIXTE LAPUYADE . . . . . *President*
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B. F. DEARING, M. D. . . . . *Chairman of Staff*

A general hospital of 225 beds operating an accredited School of Nursing, admitting all classes of patients except those suffering from mental diseases. Organized in 1851 and operated by the French Mutual Benevolent Society through a Board of Directors, a chief executive officer and staff. Accredited for intern training by the American Medical Association and approved by the American College of Surgeons.

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INTERNAL MEDICINE INCLUDING FUNCTIONAL AND ORGANIC NERVOUS SYSTEM DISEASES

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Address: STEPHEN SMITH, M. D., F. A. C. P.; CHARLES W. THOMPSON, M. D., F. A. C. P.
MEDICAL DIRECTORS, PASADENA, CALIFORNIA

TWENTY-FIVE YEARS AGO

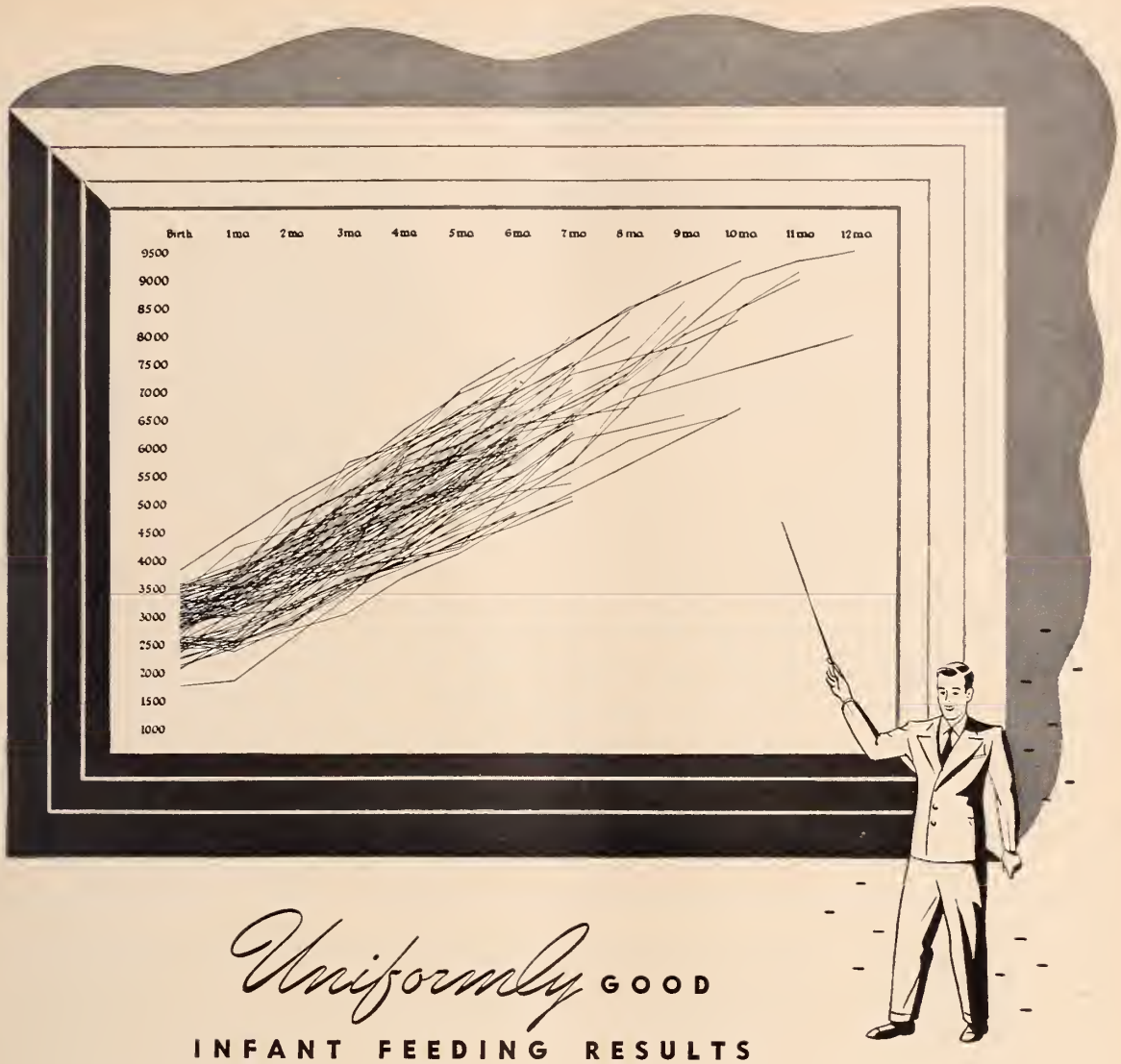
(Continued from Page 34)

is thoroughly realized. They have been presented at this time, however, not because of their intrinsic value but in order to show how much clinical knowledge could be readily obtained from such records. The complete method of group study as employed by the Diagnostic Section of St. Luke's Hospital Clinical Club is as yet unpublished. But its feasibility is so great that at once it becomes quite evident how its adoption by other hospitals would yield enough statistical material in a very short time to give a composite picture of disease in this community.

From an Original Article on "Apocodein—A New Laxative with Exceptional Advantages," by Walter C. Alvarez, M. D., San Francisco.—The more cases of constipation I see, the greater is the number in which the cause seems to me to be of a nervous or mental nature. In scores of cases I have seen it come and go according as the patient's mind was agitated or at rest. This is not so surprising when, as usually happens, the x-ray shows no sign of abnormality in the tract; the remarkable thing is that the same observation can be made in people with definite lesions interfering with colonic action. . . .

From an Original Article on "Discussion of the Pathological Division of St. Luke's Hospital Clinical Club," by E. V. Knapp, M. D., F. W. Birtch, M. D., George J. McChesney, M. D., and T. G. Inman, M. D.—If a clinician had a mind sufficiently endowed by nature, and sufficiently

(Continued on Page 38)



Uniformly GOOD
INFANT FEEDING RESULTS

The weight curves above show the normal, uneventful progress of 75 infants fed Similac for six months or longer — not a select group, but 75 *consecutive* cases. In no instance was it necessary to change the feeding because of gastro-intestinal upset. These curves were taken from hospital (name on request) records. Similarly good results are constantly being obtained in the practice of the many physicians who prescribe Similac routinely for infants deprived, either wholly or in part, of mother's milk.

A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat is removed and to which has been added lactose, vegetable oils and cod liver oil concentrate.

SIMILAC } **SIMILAR TO BREAST MILK**

M&R DIETETIC LABORATORIES, INC. • COLUMBUS, OHIO

Colfax School for the Tuberculous

COLFAX, CALIFORNIA

There are two units, The Colfax Hospital and the Bushnell Sanatorium, for the treatment of Pulmonary Tuberculosis.

The Colfax School for the Tuberculous is located in the pine clad Sierra Nevada foothills, at an elevation of 2,400 feet; an elevation free from the fogs of the valleys and free from extremes of heat or cold.

This Institution supplies, among other advantages:

1. Individual care and supervision under skilled physicians.
2. Education as to the essentials of recovery from, and the prevention of the spread of, disease.
3. Complete laboratory and x-ray equipment.
4. Every proved method of treatment, including pneumothorax and phenric nerve interruption. (Major thoracic surgery referred to skilled thoracic surgeons.)
5. An absence of institutional atmosphere.
6. Reasonable rates.

For further information write

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COLFAX, CALIFORNIA

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Consultant, General Surgery

EMILE HOLMAN, M. D.
(Stanford Hospital), Consultant, Thoracic Surgery

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2200 Hayes Street

SAN FRANCISCO, CALIFORNIA

Conducted by Sisters of Mercy

Accredited by the American Medical Association and Approved by the American College of Surgeons. Open to all members of the California Medical Association. Accredited School of Nursing and Out-Patient Department.

TWENTY-FIVE YEARS AGO

(Continued from Page 36)

cultured by study to be able to appreciate all that is known about anatomy, surgery, pathology, and all other divisions of medicine, and he also had at his disposal time to make examinations of his patient in each of these branches, he would have a most comprehensive, correlated clinical picture; but each division of medicine has developed so extensively that it is impossible to ascertain full knowledge of any one. Furthermore, no individual could systematize his time so that he could cover all divisions of medicine in all cases even though he had the ability to do so. Then the clinical picture must be blurred the further the clinician specializes his work. Since specialization is a necessity, depending on human mental limitation, it must be accepted. On the other hand, the limitation of study and practice along lines of personal interest and adaptability has its advantages, for within them it is more nearly possible to attain perfection. The difficulty is, however, that a clinician who interprets the ills of his patient partly through written reports of various specialists who have not studied the case as a whole, is not always bringing the whole knowledge of each of them to bear on the case. One or more of these specialists might add to or subtract from their reports were it possible for each to see the case from all other angles. It is evident, then, that isolated written reports are not always easy to correlate into one comprehensive picture because the facts are not all present. In order that the unwritten information of the various clinicians should not be lost, St. Luke's Hospital Clinical Club organized its Diagnostic Section, which provides that, after the reports are written, the members of the section must meet and add facts to their reports from their

(Continued on Page 40)

Do You Know Your Sulfonamides?

SULFANILAMIDE

WHICH SHALL I USE FOR GONORRHEA?

SULFAPYRIDINE

WHAT'S GOOD FOR "STREP"?

WHICH PRODUCES BEST RESULTS IN PNEUMONIA?

SULFATHIAZOLE

MY PATIENT HAS A "STAPH" INFECTION—WHAT SULFONAMIDE IS MOST EFFECTIVE?

The sulfonamide compounds continue to grow in importance. Three separate drugs have been accepted by the Council on Pharmacy and Chemistry of the A. M. A. Another has been submitted for acceptance. We present on this page the "box score" on three "sulfa" drugs now in widespread use.

	Sulfanilamide N.N.R.	Sulfapyridine N.N.R.	Sulfathiazole N.N.R.
CHEMICAL NAME	(p-amino-benzene sulfonamide)	(2-sulfanilyl aminopyridine)	(2-sulfanilyl aminothiazole)
SOLUBILITY in 100 cc. of water at 37.5° C.	1480 mg.	54 mg.	96 mg.
PHARMACOLOGY Absorption	Relatively uniform and rapid.	Irregular and often poor.	Uniform—very rapid.
Distribution	In all body fluids.	In all body fluids.	In blood but poorly in other body fluids.
Excretion	Rapid.	Slower than Sulfanilamide.	Rapid.
Tendency to conjugation.	Slight.	Marked.	Moderate.
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HOW SUPPLIED BY SQUIBB Tablets	5 grain in bot. of 100, 500, 1000. 7½ grain in bot. of 25, 100, 1000.	0.5 gram in bot. of 50, 100, 1000.	0.5 gram in bot. of 50, 100, 500, 1000.
Powder	4 oz. Rx. bottle.	5 gram vials.	
Crystals	1.0 gram ampuls, box of 5 and 25.		5 gram vials.
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TWENTY-FIVE YEARS AGO

(Continued from Page 38)

general knowledge, until the clinical picture is clear to all as if the whole had been done by one. . . .

From News Items:

A Notable Patent Medicine Suit.—The outcome of a recent suit for damages claimed by a proprietary medicine concern from the American Medical Association, which through its journal had unfavorably commented upon the curative and other claims for this preparation, may serve as an illustration of the present ethical status of the medical profession as well as of the high standard maintained by the American Medical Association, which represents the best interests of the public. . . .

. . . *The Journal of the American Medical Association* says truly in its number of July 15: "The Association has the support, numerically and intellectually, of the profession and is rapidly gaining the support of the public." The *Sun* has recognized the former and has endeavored to further the latter. The Association's work is, in fact, primarily in the interests of the lay public, for its function is to protect the innocent from the menace of quackery and the danger to health and life from faith in the unfounded, misleading, and frequently false promises and claims of charlatans.—*New York Sun*, July 25.

"Medical Preparedness League."—A course of instructions under the auspices of the Medical Preparedness Section of the County Medical Society every Thursday from 4:30 to 5:30 p. m., for fourteen weeks, beginning Sep-

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(Continued from Page 40)

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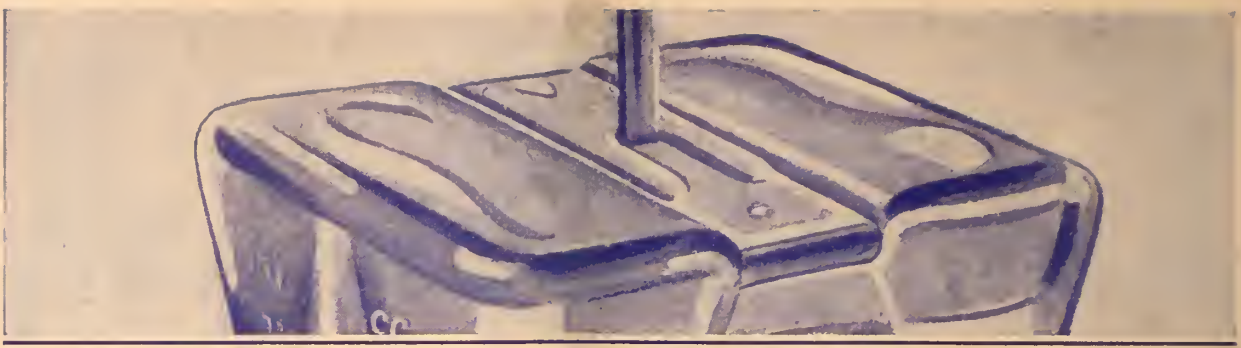

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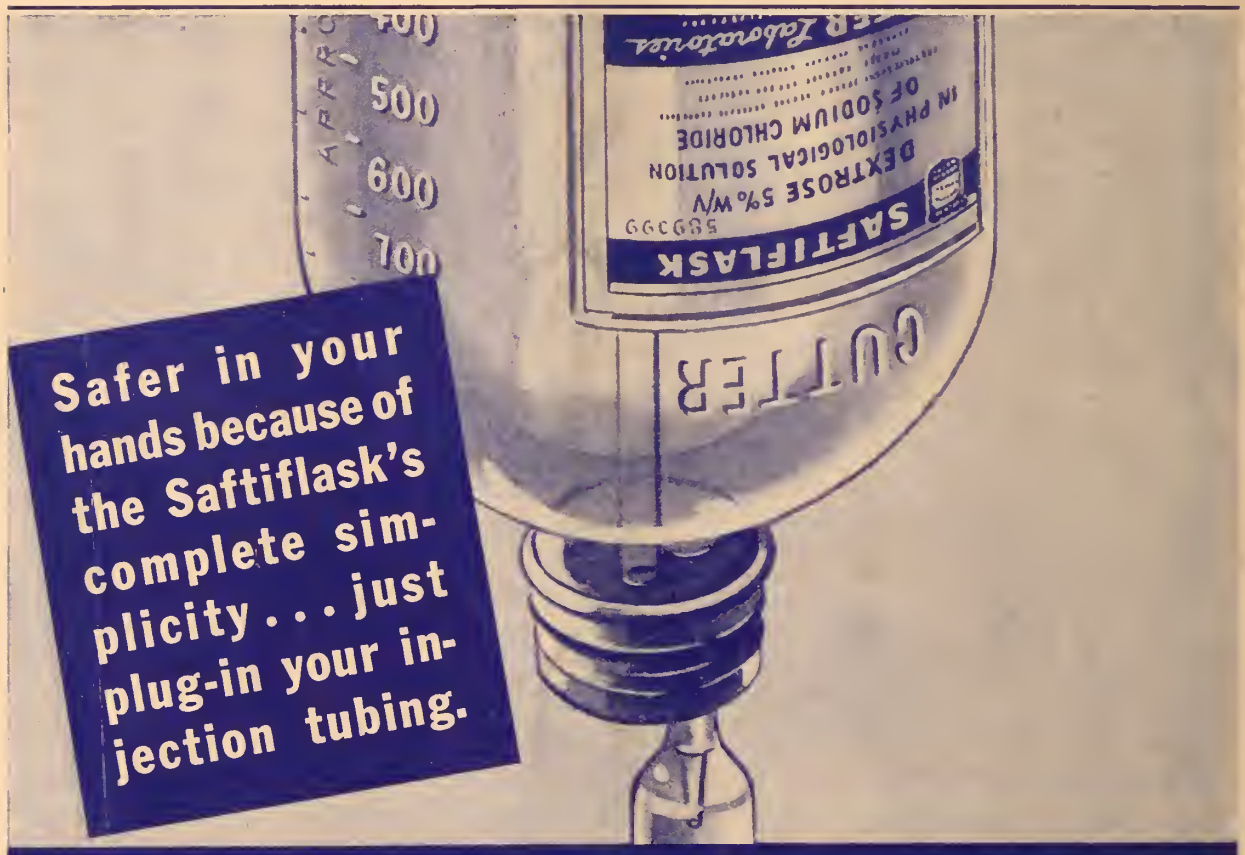

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(Continued on Page 5)

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ROSTER OF COUNTY MEDICAL SOCIETIES, CALIFORNIA MEDICAL ASSOCIATION

(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association
2404 Broadway, Oakland
President, John W. Sherrick, 350 Twenty-ninth Street, Oakland.
Secretary, Gertrude Moore, 353 30th Street, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn County Medical Society
President, Charles Benninger, Jr., Oroville.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, R. J. P. Harmon, 314 Tenth Street, Richmond.
Secretary, L. Abbott Hedges, 912 Macdonald Avenue, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, Frank R. Ruff, 1234 S Street, Fresno.
Secretary, J. E. Young, 405 Rowell Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Lowell G. Kramar, 1049 Main Street, Fortuna.
Secretary, Joseph S. Woolford. 350 E Street, Eureka.
Meeting. *First Thursday.*

Imperial County Medical Society
President, William A. Clarke, 132 Fifth Street, Holtville.
Secretary, Claude F. Peters, 722 Main Street, El Centro.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, H. W. Crook, 106 S. Main, Bishop.
Secretary, George Shultz, 124 N. Main, Lone Pine.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society
President, Lucille B. May, 1706 Chester Ave., Bakersfield.
Secretary, Sophie M. Loven, 458 Haberfelde Building, Bakersfield.
Meeting, *Third Thursday, 8:00 p. m.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, Arthur Zeismer, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, W. B. McKnight, Portola.
Secretary, Bernard S. Holm, Quincy.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles
President, Thomas C. Myers, 1501 So. Figueroa Street, Los Angeles.
Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, Wilson P. Goddard, 308 Throckmorton Street, Mill Valley.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, Deer Park Villa, Fairfax.*

Mendocino-Lake County Medical Society
President, Royal Scudder, 123 Laurel Street, Fort Bragg.
Secretary, Otto L. Gericke, Mendocino State Hospital, Talmage.
Meeting, *on Call.*

Merced County Medical Society
President, A. B. Bigler, 165 N. Second Street, Chowchilla.
Secretary, James A. Parker, Bank of America Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, James McPharlin, 8 East Alisal Street, Salinas.
Secretary, R. D. Mace, 601 South Main Street, Salinas.
Meeting, *First Thursday.*

Napa County Medical Society
President, R. C. Burkett, 1130 First Street, Napa.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, Lawrence C. Cameron, 218 South Main Street, Santa Ana.
Secretary, Milo K. Tedstrom, 1626 Bush Street, Santa Ana.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society
President, Lucas W. Empey, Roseville.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Wayne K. Templeton, 3770 Twelfth Street, Riverside.
Secretary, Hobart M. Kelly, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Frank Warne Lee, 510 Physicians Building, Sacramento.
Secretary, Curtis H. McDonnell, California State Life Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Eugene H. Hull, San Bernardino.
Secretary, A. E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
1410 Medico-Dental Building, 233 A Street, San Diego
President, Frank A. St. Sure, 4067 Van Dyke Avenue, San Diego.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
2180 Washington Street, San Francisco
President, Harold A. Fletcher, 490 Post Street, San Francisco.
Secretary, L. Henry Garland, 2180 Washington Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, Raymond Leroy Owens, 28 Cory Building, Lodi.
Secretary, George H. Rohrbacher. 1005 Medico-Dental Building, Stockton.
Acting Secretary, C. A. Broaddus, 242 North Sutter Street, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, Horace Hagan, 1215 Chorro Street, San Luis Obispo.
Secretary, E. M. Bingham, County Health Department, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, H. H. Whitney, 1204 Burlingame Avenue, Burlingame.
Secretary, Thomas Farthing, 23 Second Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, H. R. Schwalenberg, Cottage Hospital, Santa Barbara.
Secretary, D. H. McNamara, 317 W. Pueblo Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society
President, A. J. Baiocchi, 369 South Third Street, San Jose.
Secretary, Leon P. Fox, Ste. Claire Building, San Jose.
Meeting, *Third Monday, 7:00 p. m., Sainte Claire Hotel, San Jose.*

Santa Cruz County Medical Society
President, Avery Wood, 335 Main Street, Watsonville.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meeting, *First Tuesday of each month (except June, July and August), 7:30 p. m., Club Rio del Mar, Aptos.*

Shasta County Medical Society
President, Earnest Dozier, Redding.
Secretary, Julius M. Kehoe, Redding.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, F. W. Martin, 106 Orem Street, Mt. Shasta.
Secretary, Victor W. Hart, 113 No. Oregon Street, Yreka.
Meeting, *Sunday on call.*

Solano County Medical Society
President, Gordon Bunney, Suisun.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Tuesday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, Leighton Ray, 536 B Street, Santa Rosa.
Secretary, John O. Raffety, 505 B Street, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Hoyt R. Gant, 1024 J Street, Modesto.
Secretary, A. E. Ghilotti, 1024 J Street, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
President, R. G. Frey, Red Bluff.
Secretary, F. J. Bailey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Ray E. Cronemiller, 160 South E Street, Exeter.
Secretary, Forrest G. Powell, 222 W. Willow Street. Visalia.
Meeting, *Sunday Evening once a month.*

Ventura County Medical Society
President, James W. Moore, 23 S. California Street, Ventura.
Secretary, Robert K. Harker, 132 Fourth Street, Oxnard.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, Edwin K. Copeland, 405 First Street, Woodland.
Secretary, Wilfred T. Robbins, 719 Second Street, Davis.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
President, Romayne B. Whitney, Plumas Street, Yuba City.
Secretary, Leon M. Swift, I. O. O. F. Building, Marysville.
Meeting, *Second Wednesday.*

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1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," Am. J. Syph., Gon. & Ven. Dis., 23, 201 (March), 1939.

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California Packet Library Services

In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco.

Barlow Medical Library (Los Angeles County Medical Association), 634 South Westlake, Los Angeles.

Nonprofit Hospitalization Corporations

In California, the three nonprofit hospitalization corporations named below are in operation:

Hospital Service of California, 333 Pine Street, San Francisco; 675 East Santa Clara, San Jose; 364 Fourteenth Street, Oakland.

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Request is made that any member who desires to submit papers before an annual session section, write in regard thereto, to respective section secretary, as soon as convenient after the close of an annual session.

Anesthesiology

Chairman, Dorothy Wood, University of California Hospital, San Francisco.
Secretary, Ernest H. Warnock, 1136 West Sixth Street, Los Angeles.

Dermatology and Syphilology

Chairman, Henry Sutherland Camphell, 1930 Wilshire Boulevard, Los Angeles.
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Eye, Ear, Nose and Throat

Chairman, Warren D. Horner, 490 Post Street, San Francisco.
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Assistant Secretary, J. Norton Nichols, 1930 Wilshire Boulevard, Los Angeles.

Industrial Medicine and Surgery

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Chairman, James A. Cutting, Agnew State Hospital, Agnew.
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Obstetrics and Gynecology

Chairman, C. F. Fluhmann, Stanford University Hospital, San Francisco.
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Robert A. Peers, Colfax	(1941-1942)	Frederick N. Scatena, Sacramento
William R. Molony, Sr., Los Angeles	(1941-1942)	John C. Ruddock, Los Angeles
Elhridge J. Best, San Francisco	(1942-1943)	L. R. Chandler, San Francisco
Lyell C. Kinney, San Diego	(1942-1943)	Bon O. Adams, Riverside
Harry H. Wilson, Los Angeles	(1942-1943)	Roy E. Thomas, Los Angeles
Henry S. Rogers, Petaluma	(1942-1943)	Philip K. Gilman, San Francisco

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Butte-Glenn County—President, Mrs. C. C. Landis, 1081 Woodland Avenue, Chico.
Contra Costa County—President, Mrs. Thomas Dozier, 507 Tenth Street, Antioch.
Fresno County—President, Mrs. J. R. Walker, Rt. 3, Box 528, Fresno.
Humholdt County—President, Mrs. Allan Watson, 2317 D Street, Eureka.
Inyo-Mono County—President, Mrs. H. W. Crook, 106 South Main, Bishop.
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Kings County—President, Mrs. C. T. Rosson, Jr., 1507 No. Redington Street, Hanford.
Lassen-Plumas-Modoc County—President, Mrs. Fred J. Davis, Jr., 920 Pine Avenue, Susanville.
Los Angeles County—President, Mrs. Ralph B. Eusden, 4360 Myrtle Ave., Long Beach.
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Merced County—President, Mrs. C. C. Fitz Gihhon, 650 Twenty-sixth Street, Merced.
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Riverside County—President, Mrs. Frederick Veitch, 3660 Fourteenth Street, Riverside.
Sacramento County—President, Mrs. George A. Briggs, 1127 Forty-fifth St., Sacramento.
San Diego County—President, Mrs. E. H. Christopherson, 2876 Nutmeg, San Diego.
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San Mateo County—President, Mrs. Otis Allen Sharpe, 617 Crescent Ave., San Mateo.
Santa Barhara County—President, Mrs. C. W. Henderson, 130 E. Pedregosa Street, Santa Barhara.
Santa Clara County—President, Mrs. Philip Haley, 1155 Emory Street, San Jose.
Santa Cruz County—President, Mrs. Norman Sullivan, 457 Laurel Street, Santa Cruz.
Solano County—President, Mrs. F. Burton Jones, P. O. Box 425, Vallejo.
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Tulare County—President, Mrs. George Keiper, 318 West School Street, Visalia.
Ventura County—President, Mrs. Walter F. Mosher, 2246 E. Main Street, Ventura.

Miscellaneous California Medical Organizations

Department of Public Health of the State of California

San Francisco—603 Phelan Building, 760 Market Street, San Francisco; UNderhill 8700.
Sacramento—State Office Building, Tenth and L streets, CApital 2800.
Los Angeles—State Office Building, 217 West First Street, MAdison 1281.
President, Elmer Belt, Los Angeles.
Director, Bertram P. Brown, 603 Phelan Building, 760 Market Street, San Francisco.

California Northern District Medical Society

President—John H. White, Chico.
Secretary—J. Homer Woolsey, Woodland Clinic, Woodland.

Board of Medical Examiners of the State of California

San Francisco, Rm. 214, 515 Van Ness Ave.
Los Angeles. 906 State Building.
Sacramento, Business and Proiessional Bldg., 1020 N Street.
President, Clark L. Abhott, Oakland.
Secretary, C. B. Pinkham. Room 214, 515 Van Ness Avenue, San Francisco.

Southern California Medical Association

President, Alvin Foord, 749 Fairmont Ave., Pasadena.
Secretary, Edward W. Boland, 2202 W. Third Street, Los Angeles.

The Puhlic Health League of California

Executive Secretary, Ben H. Read, San Francisco office, 244 Kearny Street, phone SUtter 8470. Los Angeles office, Room 563, 1151 South Broadway, phone PRospect 5711.

Medical Schools of California

University of California Medical School, Third and Parnassus, San Francisco. Agnes L. Terry, Assistant to the Dean.
Stanford University School of Medicine, 2398 Sacramento Street, San Francisco. L. R. Chandler, M. D., Dean.
University of Southern California Medical School, 1100 N. Mission Road, Los Angeles. Paul S. McKihhen, Sc. D., Dean.
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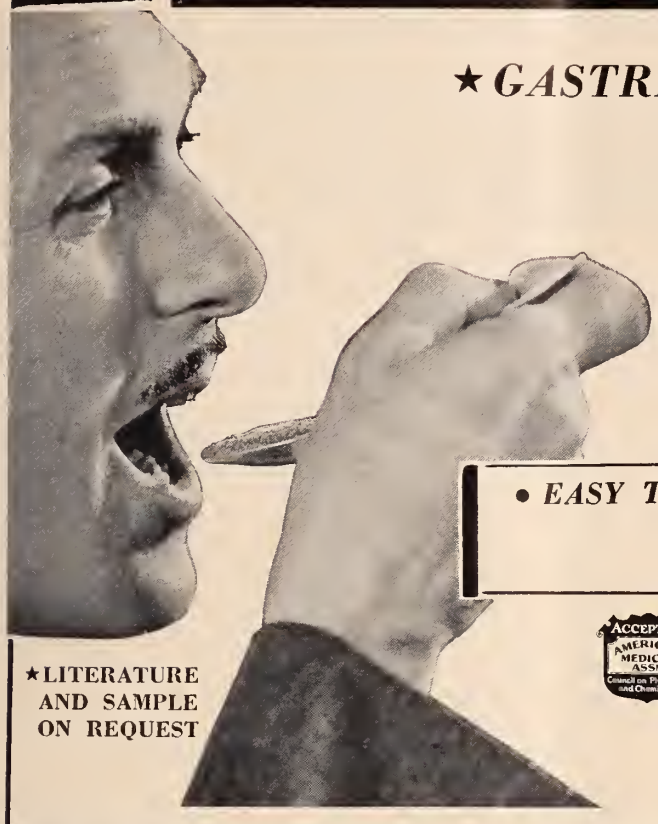

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BOOKS RECEIVED

Cardiac Clinics: A Mayo Clinic Monograph. By Fredrick A. Willius, B. S., M. D., M. S. in Med., Head of Section of Cardiology, Mayo Clinic, and Professor of Medicine, Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota, Rochester, Minnesota. Cloth. Pp. 276, with 19 illustrations. St. Louis: The C. V. Mosby Company, 1941.

Handbook of Communicable Diseases. By Franklin H. Top, A. B., M. D., M. P. H., Director, Division of Communicable Diseases and Epidemiology, Herman Kiefer Hospital and Detroit Department of Health; Associate Professor of Preventive Medicine and Public Health, Wayne University, College of Medicine; Special Lecturer in Communicable Diseases and Epidemiology, University of Michigan; Major, Medical Reserve Corps, United States Army; and Collaborators. Cloth. Pp. 682, with 73 text illustrations and 10 color plates. St. Louis: The C. V. Mosby Company, 1941.

Fatal Partners: War and Disease. By Ralph H. Major, M. D. Cloth. Pp. 342, with 11 illustrations. New York: Doubleday, Doran & Company, Inc., Garden City, 1941.

Microbes Which Help or Destroy Us. By Paul W. Allen, Ph. D., Professor of Bacteriology and Head of the Department, University of Tennessee; D. Frank Holtman, Ph. D., Associate Professor of Bacteriology, University of Tennessee; and Louise Allen McBee, M. S., Formerly Assistant in Bacteriology, University of Tennessee. Cloth. Pp. 540, with 102 text illustrations and 13 color plates. St. Louis: The C. V. Mosby Company, 1941.

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BOOKS RECEIVED

(Continued from Page 7)

Synopsis of Applied Pathological Chemistry. By Jerome E. Andes, M. S., Ph. D., M. D., F. A. C. P., Director of Department of Health and Medical Advisor, University of Arizona, Tucson; Formerly Assistant Professor of Pathology and Clinical Pathology, West Virginia University Medical School, and A. G. Eaton, B. S., M. A., Ph. D., Assistant Professor of Physiology, Louisiana State University School of Medicine, New Orleans. Cloth. Pp. 428, with 23 illustrations. St. Louis: The C. V. Mosby Company, 1941.

Sulfanilamide and Related Compounds in General Practice. By Wesley W. Spink, M. D., Associate Professor of Medicine, University of Minnesota Medical School. Cloth. Pp. 256. Chicago, Illinois: The Year Book Publishers, Inc.

The New International Clinics. Original Contributions; Clinics; and Evaluated Reviews of Current Advances in the Medical Arts. Edited by George Morris Piersol, M. D., Professor of Medicine, Graduate School of Medicine, University of Pennsylvania, Philadelphia, Pennsylvania. With the Collaboration of Francis Gilman Blake, M. D., Yale University, New Haven; Russell L. Cecil, M. D., Cornell University, New York; Vernon C. David, M. D., Rush Medical College, Chicago; Nicholson Joseph Eastman, M. D., Johns Hopkins University, Baltimore; Karl Musser Houser, M. D., University of Pennsylvania Hospital, Philadelphia, Pennsylvania; William John Kerr, M. D., University of California, San Francisco; John W. McNee, D. S. O., M. D., University College Hospital, London; Jonathan C. Meakins, M. D., McGill University, Montreal; George Richards Minot, M. D., Harvard University, Boston; John Walker Moore, M. D., University of Louisville, Louisville; John Herr Musser, M. D., Tulane University, New Orleans; Lewis J. Pollock, M. D., Northwestern University, Chicago; Isidor S. Ravdin, M. D., University of Pennsylvania, Philadelphia; Borden Smith Veeder, M. D., Washington University, St. Louis; George Barclay Wallace,

(Continued on Next Page)

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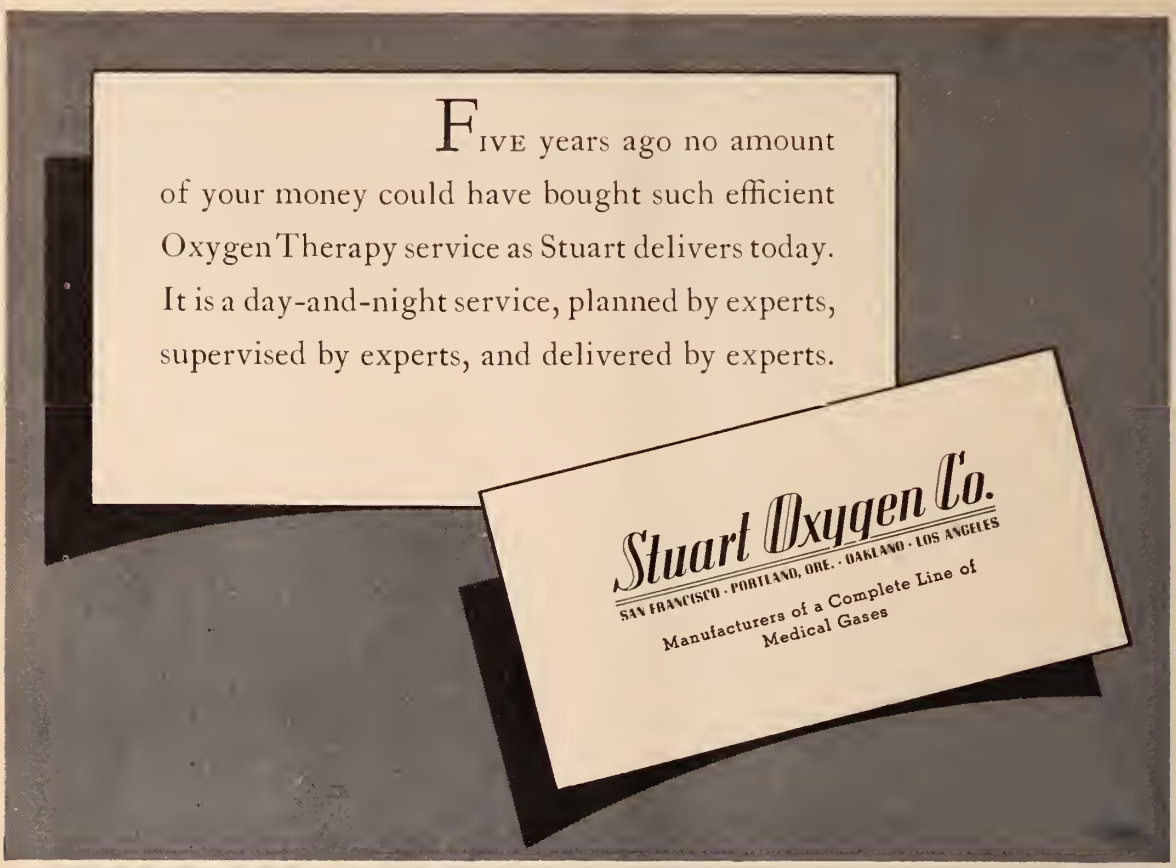

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BOOKS RECEIVED

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M. D., New York University, New York; Russell M. Wilder, M. D., Mayo Foundation, Rochester; Alan C. Woods, M. D., Johns Hopkins University, Baltimore. Cloth. Pp. 300, with 13 illustrations. Philadelphia, Montreal, New York: J. B. Lippincott Company.

Essentials of General Surgery. By Wallace P. Ritchie, M. D., Clinical Assistant Professor, Department of Surgery, University of Minnesota Medical School. Cloth. Pp. 813, with 237 illustrations. St. Louis: The C. V. Mosby Company, 1941.

BOOK REVIEW

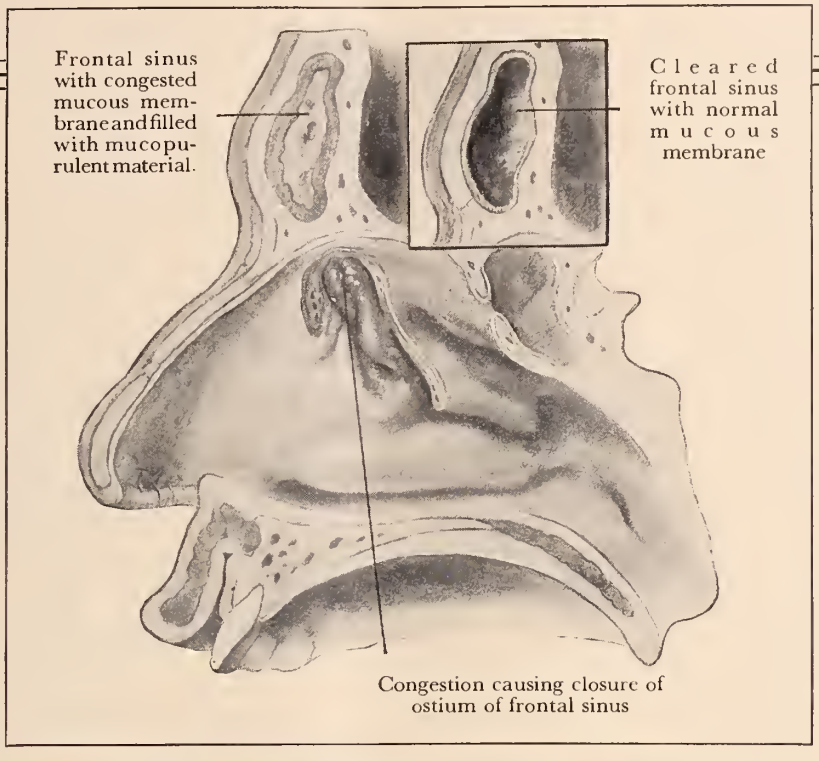
Anus, Rectum, Sigmoid Colon; Diagnosis and Treatment. By Harry Ellicott Bacon, B.S., M.D., F.A.C.S., F.A.P.S. Philadelphia, Montreal, and London: J. B. Lippincott Company, 1941.

The author of an excellent encyclopedic textbook covering a specialized branch of surgery such as is Dr. H. E. Bacon's new book, "Anus, Rectum, and Sigmoid," could not reasonably expect more than to have his book so widely accepted as to require a second edition in seventeen months, and to require translation in several foreign languages. One has only to peruse this second edition a short time to become convinced that the demand will exceed that of the first edition. Diseases and abnormalities affecting the anus, rectum and sigmoid colon could not be more thoroughly discussed and illustrated in a one-volume work than the author has accomplished in this boook.

The detailed surgical anatomy is nicely presented. Methods of examination and diagnosis are carefully discussed and generously illustrated. About twenty-five pages are given to an unbiased and complete discussion of the various types of anesthesia with the advantages and disadvantages carefully outlined. The author has fortunately given due consideration to all conditions involving the anus, rectum and sigmoid colon, be they ever so minor.

(Continued on Page 14)

PATHOLOGY OF THE UPPER RESPIRATORY TRACT



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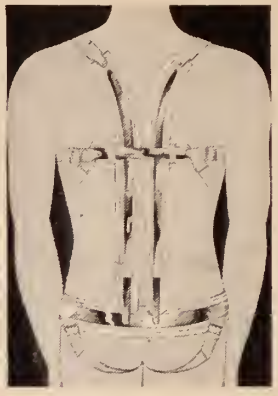

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BOOK REVIEWS

(Continued from Page 10)

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Any physician who is interested in diseases of the anus, rectum and sigmoid colon should avail himself of Doctor Bacon's excellent volume.—A. H. Lorch, M. D.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 224)

are having their origins now. Many of the states in this country are, by statute and constitutional amendment, creating revolutionary sociologic conditions; bringing into existence in the space of a few months or years absolutely radical conditions and such as in other countries it has taken generations to develop. No wonder there are differences of opinion; no wonder there are innumerable petty complications and contradictions of more or less importance. To begin with, the whole question is susceptible of division into two absolutely distinct lines of thought and opinion: Shall the human race develop in its own unrestrained, untrammeled way, except for necessary police regulations? Or, on the other hand, shall its course of development be artificially changed, altered and modified by sumptuary legislation which really has its basic origin

(Continued on Page 16)

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TWENTY-FIVE YEARS AGO

(Continued from Page 14)

in the fundamental idea of paternalism? Who can possibly answer the question: Is social insurance in all its forms of benefit or not? Perhaps at the end of one or two centuries someone may be able to answer correctly the question, but no one at the present time can do more than express an opinion of conjecture.

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Changes in Medicine.—"Medicine," using the word in its broadest sense, as a profession, calling, or occupation, is changing very rapidly; more rapidly than most of us

(Continued on Page 18)

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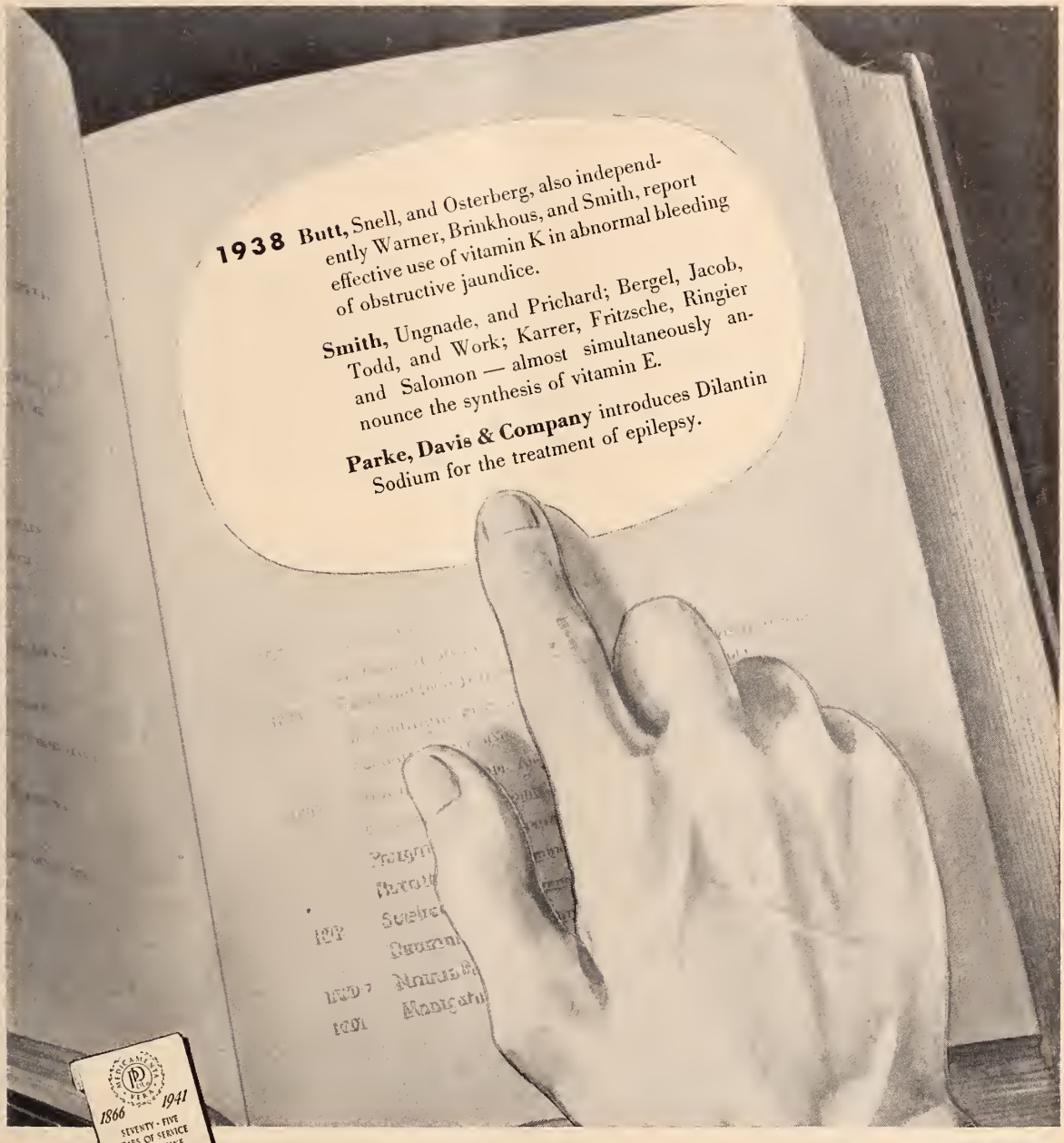

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TWENTY-FIVE YEARS AGO

(Continued from Page 16)

believe or understand, and so rapidly that many physicians resent the results of the changes without realizing their cause or their import. The tendency is toward State Medicine. Within the profession itself we see the same tendency. The development of refined methods of diagnosis, requiring skilled men in different lines of specialized activity, has brought about, without its being realized, what has been called the "group plan" of practicing. Such groups of physicians are in many cases united on a thorough business basis, and are conducting the professional work of the group just as, since time immemorial, groups of business men have been conducting their commercial activities. . . .

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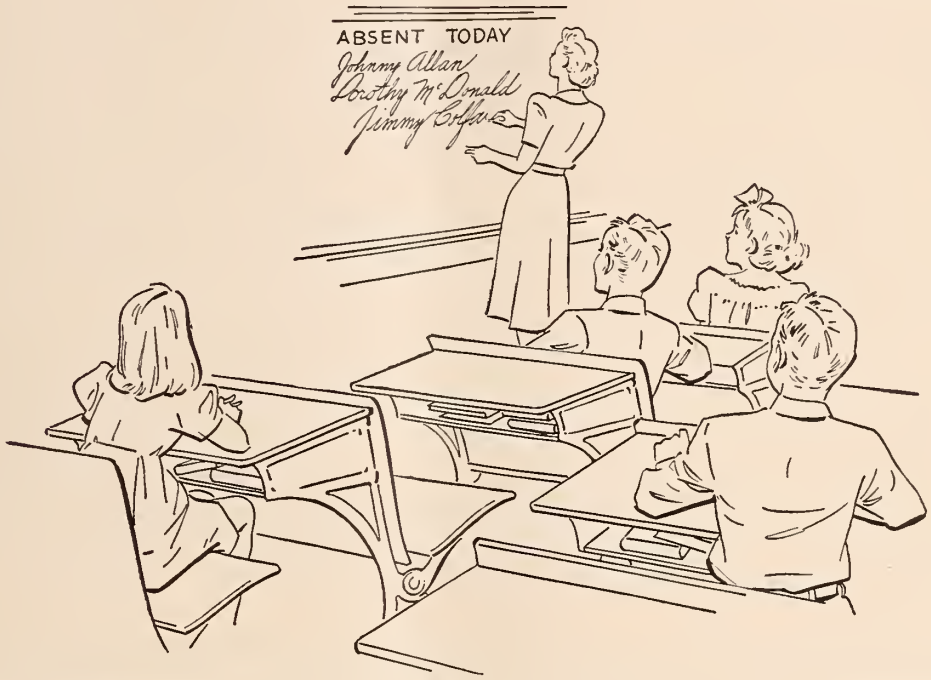
Identifying Records.—This time we do not refer to the records which a physician keeps, or should keep, but to

(Continued on Page 20)

Home with a head cold



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(Continued from Page 18)

the records which are being accumulated in the office of the State Society. We wish to have all the information about physicians located in California that it is possible to collect. We desire very much both a photograph of every physician and a specimen of his handwriting. It would astonish you to know how often this office is called upon to identify some particular physician, or to give some information in regard to him. Hardly a day goes by that this is not the case. In San Francisco a photograph studio offered to take a photograph of any physician free of charge and to furnish us with a copy free of charge. We, therefore, wrote a letter which this studio sent out, setting forth these facts. . . .

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EXCERPTS FROM MISCELLANEOUS ARTICLES

From an Article on "Infection Psychoses and the Symptom Picture of Mental Confusion," by A. W. Hoisholt, M. D., and W. T. Harrison, M. D., Napa State Hospital.—

(Continued on Page 22)

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TWENTY-FIVE YEARS AGO

(Continued from Page 20)

Mental confusion as a disease picture or syndrome is met with almost as frequently as the symptom-complex of mental depression or melancholia. As a disease picture it is very striking and easily recognized, which is the reason why the layman always agrees that the person who is confused and talks disconnectedly must be crazy, while he rebels against considering the man really insane who is only despondent or elated. Mental confusion has been for ages the ideal landmark of insanity to dramatists and poets, and it has been portrayed on the stage with more or less success. . . .

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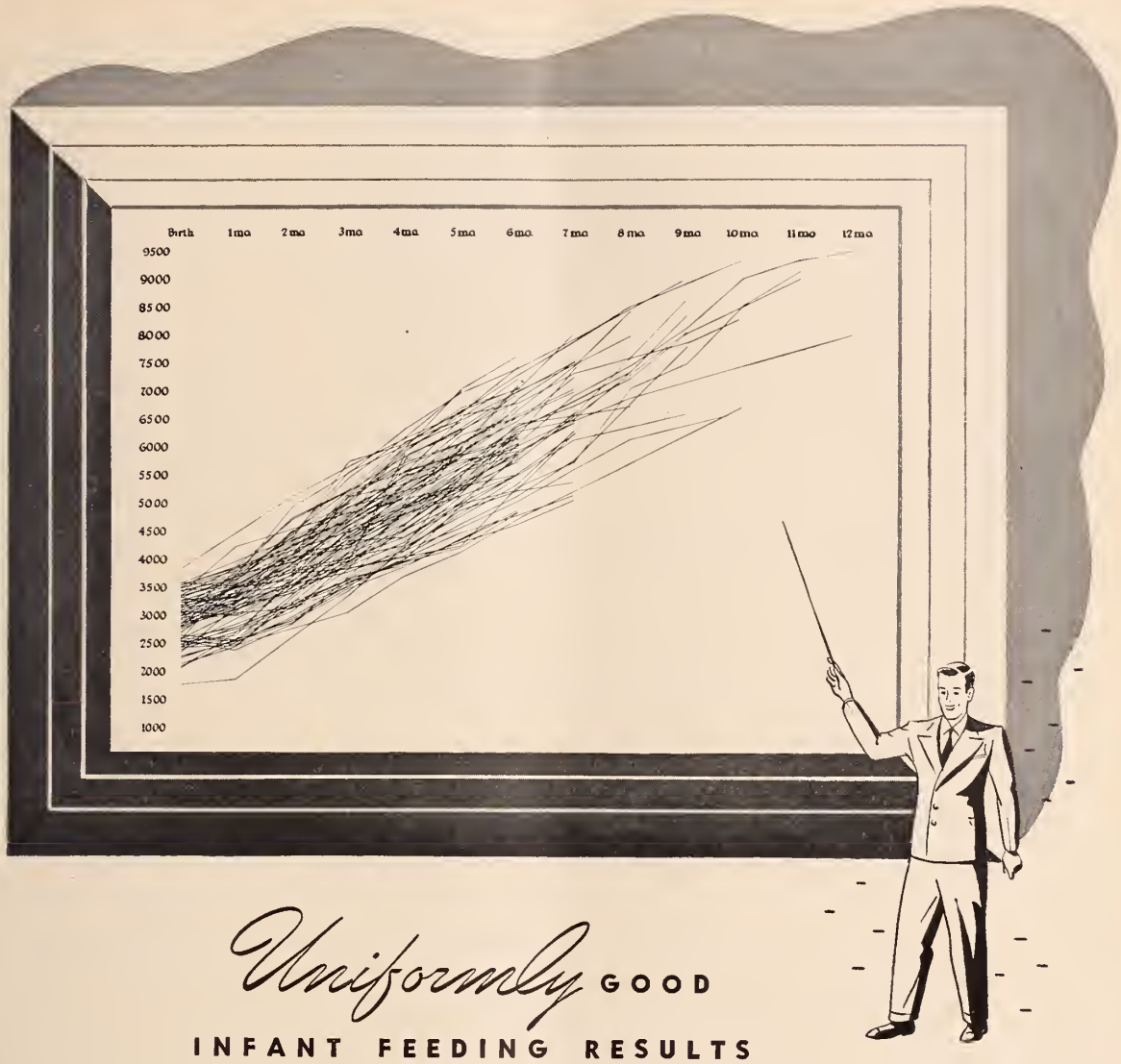
From an Article on "Septic Teeth," by John S. Marshall, M. D. (Captain, United States Army, Retired).—The object of your essayist in presenting this subject is to place before you certain facts in relation to the pathology of these teeth, and a few practical suggestions as to their treatment, gained from clinical experience. . . .

From an Article on "The Consideration of Rectal and Colonic Disease in Life Insurance Examinations," by Alfred J. Zobel, M. D., San Francisco.—When making a

(Continued on Page 24)



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TWENTY-FIVE YEARS AGO

(Continued from Page 22)

life insurance examination the careful examiner does not rely upon any of the applicant's statements regarding his present physical condition, but by inspection he notes whether the general appearance is healthy or unhealthy; by inspection, palpation, percussion and auscultation he secures accurate information concerning the heart and lungs; by examination of the reflexes, etc., he seeks evidence of disease or functional derangement of the brain and nervous system; by palpation and with the sphygmomanometer he determines the condition of the blood vessels; by an urinalysis he sees if the kidneys and bladder are free from any tendency to disease; by the thermometer he notes the untoward rise in temperature, which betrays latent disease; and by the scales and the tape he finds variations from normal in weight and measurements. All this important data are obtained only by direct examination and by precise methods. . . .

From an Article on "Résumé of Epidemiological Investigations of Epidemics of Poliomyelitis with Reference to Contagiousness," by J. C. Geiger, M. D., and Frank L. Kelly, M. D., Berkeley.—The present epidemic of acute anterior poliomyelitis in New York City, with the possible danger of its spread to California, makes it necessary that we consider the vitally important epidemiological data that have been gathered in the various outbreaks of this disease. We may preface this discussion by stating that to no one factor can the spread of the disease in a community be absolutely attributed. It is for this reason that the methods of prophylaxis and control are largely theoretical and indefinite. Nevertheless, we are justified in using every means at our disposal for the protection of the public. . . .

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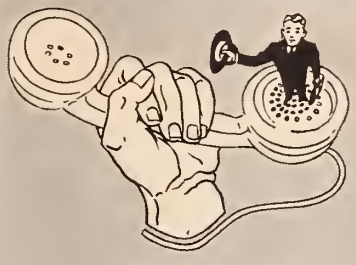

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400 FIRST NATIONAL BANK BUILDING • OMAHA, NEBRASKA

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 224)

"Dr. Frank J. Tillman, sixty-seven, 841 Yale Avenue, today was fined $100 as one of the terms of six months' probation granted by Police Judge M. K. Gibbs on a charge of treating a narcotic addict in violation of state laws. The terms of probation also include the requirement Doctor Tillman refrain from prescribing narcotics. The probation officer reported Doctor Tillman already has surrendered his record book and prescription blanks for narcotics. He was arrested by a state narcotics inspector who said he had been warned against treating addicts on previous occasions." (Fresno *Bee*, August 15, 1941.)

"Florida cracker James A. Brownlow, alias Dr. James B. Lorring, a recent drummer for the Salvation Army band here, was in jail today awaiting trial on a forgery and grand theft rap. Brownlow, whose record reveals he is well acquainted with prisons from Florida to Hawaii, wound up in the clink on a series of bad check charges. It turns out that he cashed some worthless checks endorsed by his wife, a woman physician he married just last June 28. She was Dr. Josephine Martin, 1007 South Bronson Avenue, who was wed to the man she knew as Doctor Lorring in Las Vegas, Nevada, three days after they met in a cocktail lounge here. The meeting happened when Brown low took time out from his drumming for a little refresher, and he wound up becoming acquainted with Doctor Martin. The denouement came, however, after Brownlow took a powder on July 14, leaving a flock of creditors who had cashed his checks holding the bag. Police were notified of the phoney physician's disappearance, and a picture of him taken at a party he attended with his bride matched up

(Continued in Back Advertising Section, Page 30)

When Baby got there, the Cupboard was-crammed!

A Liberal protein content

B An adjusted protein (added gelatin)

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D Two added sugars

E Added vitamin B complex

F 4 times as much iron as cows' milk

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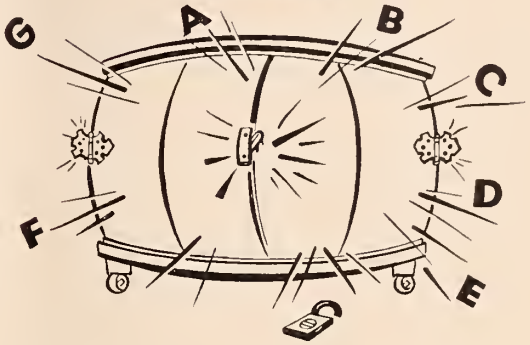

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The doctrine of Baker's "well filled cupboard" is gaining wide acceptance in infant feeding, doctor. We'll gladly send you full information about it.

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CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 55 OCTOBER, 1941 NO. 4

California and Western Medicine

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Address editorial communications to Dr. George H. Kress as per address above. Address business and advertising communications to John Hunton.

EDITOR . . . . . GEORGE H. KRESS

Committee on Publications

Francis E. Toomey.....San Diego 1942
G. W. Walker.....Fresno 1943
A. A. Alexander, Chairman.....Oakland 1944
Secretary-Editor, ex officio

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number see index below.)

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

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Advertising Representative for Northern California
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Volumes begin with the first of January and the first of July. Subscriptions may commence at any time.

Change of Address.—Request for change of address should give both the old and the new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

DEPARTMENT INDEX

(Itemized Index of Articles is printed on Front Cover)

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EDITORIALS†

CALIFORNIA'S BASIC SCIENCE INITIATIVE

Initiative Petitions Now Being Circulated.—It is hoped that by the end of October every physician and dentist who holds membership in a county or district society will have received a copy of the Basic Science Initiative that will be submitted to the voters of California at the next state election—in November, 1942.*

* * *

Total of 212,117 Valid Signatures Required.—For preliminary consideration, the proposed law is referred to the medical and dental professions in petition form, because petitions containing a total of more than 212,117 validated signatures of properly registered voters must be presented to the Secretary of State before the contemplated law can be placed on the state election ballot. Through the coöperation of physicians and dentists, it is hoped that the expenditure for securing the necessary signatures will be greatly reduced. Only petitions and signatures that have been properly validated and signed can be used; and since the cost of securing signatures through commercial distributors approximates about 12 cents per name, the margin of almost 300,000 signatures that will be required to insure its acceptance by the Secretary of State, would mean an outlay of California Medical Association funds amounting to between thirty and forty thousand dollars! If physicians and surgeons, therefore, either themselves, or through properly certified office assistants, will obtain signatures from patients and friends, it should be possible to secure most of the names required without resorting to expensive commercial company circulators.†

In coöperation with the Public Health League of California, the petitions are now going forward to members of the medical and dental professions, and it is hoped that real progress will have been made in acquiring the needed signatures before the year 1941 comes to a close.

* * *

History of Basic Science Law Legislation.—For members who have not followed the history of

† Editorials on subjects of scientific and editorial interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

* For references to progress reports from Committee on Public Health Education concerning the proposed law, see the issues of CALIFORNIA AND WESTERN MEDICINE for July, page 45; August, page 96; and September, page 151.

† Read carefully the instructions and cautions on the back of the petition regarding circulators and circulation.

the Basic Science Law activities in California, and who may wish to check and be informed thereon, a list of references to basic science articles that have appeared in CALIFORNIA AND WESTERN MEDICINE, was given in the August issue, on page 104.

It is a source of gratification to know that California, one of the "multiple healing art board states," now bids fair to join the fifteen commonwealths and the District of Columbia, which already carry such a law on their statute books. The first state to enact a similar measure was Connecticut, in the year 1925, two years before California's agitation for a Basic Science Law began. The states which possess basic science laws, with years of enactment of their statutes, include: Arizona, 1936; Arkansas, 1929; Colorado, 1937; Connecticut, 1925; District of Columbia, 1929; Florida, 1939; Iowa, 1935; Michigan, 1937; Minnesota, 1927; Nebraska, 1927; Oklahoma, 1937; Oregon, 1933; Rhode Island, 1940; South Dakota, 1939; Washington, 1927; Wisconsin, 1925.

* * *

How Basic Science Laws in Other States Have Worked.—The *Journal of the American Medical Association*, on page 2052 of its issue of May 3, 1941, gave a brief discussion of basic science law statistics, from which the following figures are taken:

1. Statistics for years 1927-1940, inclusive, for all Basic Science Boards reveal the following:

(*a*) *Re: Physicians or Medical Students Examined:*

Total examined, 11,814; passed, 10,401; failed, 1,413; percentage failed, 12.0; endorsement, 2,583; total certified, 12,984.

(*b*) *Re: Other Healing Art Practitioners Examined:*

Total examined, 1,429; passed, 674; failed, 755; percentage failed, 52.8; endorsement, 407; total certified, 1,081.

Further comment on the tables submitted in the *Journal of the American Medical Association* article referred to, follows:

Five boards functioning in 1927 examined 305 physicians or medical students, of whom 26, 8.5 per cent, failed and 22 other practitioners, of whom 7, or 31.8 per cent, failed. In 1940, by comparison, 1,639 were certified. During the fourteen-year period a total of 12,984 physicians were examined, of whom 10,401 passed and 1,413, 12.0 per cent, failed and 1,429 other practitioners, of whom 52.8 per cent failed. During this period, 2,583 physicians were certified without examination, while only 407 other practitioners were so registered.

Altogether, 14,065 certificates have been issued by basic science boards since 1927, of whom 12,984 were granted to physicians and 1,081 to other practitioners. During this fourteen-year period, 11,814 physicians or medical students were examined, of whom 10,401 were registered, and 1,429 other practitioners were examined, 674 of whom received certificates. During this fourteen-year period, also 2,583 physicians and 407 others received certificates by examination, reciprocity and endorsement.

From the high percentage of failures in the other practitioner group, it seems apparent that the enforcement of basic science laws affects mostly this group. The object of such laws is to provide a means of insuring that all candidates seeking the right to care for sick and injured people shall first possess a reasonable knowledge of the sciences fundamental to the healing art.

Comment with Reference to California Conditions.—The above figures should convince any physician that a Basic Science Law is a real aid in preventing the licensure of persons who do not possess an adequate amount of preliminary or prehealing-art education. For instance, in California, the chiropractors, through their board, have licensed since 1922, about 4,000 practitioners belonging to that group. For the same period, the number of osteopathic licentiates is 1,834, of which 1,335 are "osteopathic physicians and surgeons." If the naturopathic group, whose leaders for years have been seeking recognition through a separate board, were to be given legal recognition in California, the chiropractic experience of a massive number of licentiates in a limited time period would probably be duplicated, if not increased! However, with a basic science law in operation in California, it would be possible for a separate Naturopathic Board to grant licenses only to those members of that group who, in addition to possessing the professional requirements laid down in the law for their group, presented with their applications for examination, certificates previously secured from the Basic Science Board. The basic science requirement would apply to the naturopathic, naprapathic or any other sectarian group that may come forward in the future with request for legal recognition by the State of California. The basic science law would apply to all such in the same fashion as it pertained to doctors of medicine, doctors of osteopathy and doctors of chiropractic.

No legislative action could evade this requirement, because the Basic Science Act, if once enacted as an initiative law, would then partake of the nature of a constitutional amendment, and all legislative acts pertaining thereto would be required to conform to its fundamental provisions.

* * *

Coöperation in Circulating Petitions Is Important.—In conclusion, on behalf of all those who have labored either in the cultivation of opinion or in the drafting of a Basic Science Law for California, may not the hope be expressed that every physician and dentist in the State will appreciate the importance of the issues at stake, and do his part in having his own office return to headquarters, at an early day, one or more petitions with properly validated names?

Keep in mind that the securing of such names is in itself an element that will make for wider interest, with a larger number of supporters and advocates when the time for voting on the initiative approaches. In other words, the circulation at this time of signature petitions by physicians, dentists and their friends, will make for a better guarantee that California will place the proposed Basic Science Law on its statute books in November, 1942.

NEW MEETING-ROOM PAVILION AT DEL MONTE: FOR 1942 ANNUAL SESSION

Increasing Difficulty in Finding Adequate Accommodations.—Where to find accommodations of sufficient amount and proper kind to care for the increasing needs of the California Medical

Association when its members gather in an annual session, has been a serious problem that has constantly confronted the California Medical Association Council during the last decade.

Some twenty or more years ago, when the number of members was less than half of the present membership roll of 7,001, and the scientific sections fewer, the affiliated organizations also being less, it was possible to house the yearly convention with fair comfort at one of California's larger resort hotels; either at Hotel Del Monte at Del Monte, Hotel Potter at Santa Barbara, or the Hotel del Coronado at San Diego. True, the Hotel Huntington at Pasadena and Hotel Fairmont at San Francisco were also tried, but their nearness to the metropolitan centers of Los Angeles and San Francisco resulted in only a spasmodic attendance by members in nearby residence that was far from satisfactory, considered either in scientific organization or fraternal aspect.

Since that time, fire has destroyed the old Hotel Potter at Santa Barbara, and the distance from the northern section of the State to Hotel del Coronado, with the extra time for travel required, mitigates against that well-known caravansary; it being even necessary at Coronado, two years ago, for the Association to expend many hundreds of dollars to provide the temporary construction of meeting rooms for the scientific sections.

* * *

Advantages of the Del Monte Location.—Because of its favorable location in relation to both the northern and southern sections of the State, its beautiful scenic environment, and the general accommodations, it is not surprising that, by and large, the Hotel Del Monte has been acclaimed by most members who attend the annual sessions, decidedly the place best suited for the yearly gatherings of the California Medical Association.

However, at Del Monte, as elsewhere, there has been one major defect, namely, the fact that about one-half of the twelve scientific sections of the Association were housed in meeting rooms not large enough to comfortably accommodate the audiences.

It is true that, during the last two years, with changes instituted by the Committee on Scientific Work, whereby the mornings of the four meeting days have been given over to general meetings, the Tuesday afternoon entertainment features eliminated, and the meetings of accessory organizations and activities transferred to Sunday, it has been possible to materially improve the program, so far as the convenience of members in attendance was concerned.

Nevertheless, the problem of assembly rooms of sufficient number and size to carry on meetings for twelve scientific sections during each afternoon, and other activities, was still unsolved.

* * *

A Meeting Place Pavilion Is Under Construction at Del Monte.—The Association officers have held many conferences with the Hotel Del Monte management in efforts to improve the accommodations; and in the exchange of views, it was pointed out that, if a pavilion could be erected that would house at least three of the larger and two of the smaller scientific sections, conditions would be greatly improved. It is gratifying to be able to announce that such a pavilion, to be erected to the immediate east of the East Wing of the Hotel Del Monte, has been authorized by the Board of Directors of the Hotel Del Monte, and will probably be under roof within two months. Other changes contemplate additional space for the commercial and scientific exhibits, thus permitting utilization of the sun room lobby for social gatherings, thereby doing away with the tent that has prevented the use of the beautiful terrace lounge in the past. Also, to be remembered, is this: the garden room on the ground floor will be available for the Woman's Auxiliary, so eliminating the necessity of caring for that important organization in Del Monte Lodge, through inconvenient bus accommodations.

Space is here given to tell of these prospective changes because convenient surroundings at an annual session make not only for immediate comfort, but for pleasant memories. Wherefore, California Medical Association should be able to record a peak attendance at the 1942 annual session.

* * *

Reminder to Program Participants.—Before leaving the subject, members are again reminded that those who have papers in mind should promptly inform the secretaries of Scientific Sections, and that others who will be in position to present exhibits, should be getting these in hand.* Concerning scientific exhibits and medical films, correspondence should be conducted with the Association Secretary, who is the chairman of the Committee on Scientific Work. Special request is made to members of the California Medical Association who have been carrying on research and other studies and to colleagues who are on the faculties of California's medical schools, that they give fullest coöperation so that the papers given at the 1942 annual session may measure up to the best standards and fittingly reflect the work of the physicians and surgeons of California. Obligations to the California Medical Association must not be forgotten.

PUBLIC HEALTH EXHIBITS AT COUNTY FAIRS

Approval of Public Health Exhibits Was Given by the California Medical Association House of Delegates.—More than ten years ago, at one of the meetings of State Association Secretaries and Editors held at the American Medical Association headquarters in Chicago, attention was directed to the potential values of a state fair as a medium through which valuable dissemination of public health information could be carried on. The subject was then called to the attention of the California Medical Association Council, but with many

* The roster of Section officers appears on advertising page 6 of each issue of CALIFORNIA AND WESTERN MEDICINE.

Requests for hotel accommodations should be sent to Hotel Del Monte, Del Monte, California (Carl S. Stanley, manager). The management will make all efforts to house guests at the main or in nearby hotels.

other problems confronting it, the California Medical Association was obliged to put such a project aside until the present year.

At Del Monte, in May last, approval was given by the House of Delegates to the recommendations made in the *Pre-Convention Bulletin,* and the California Medical Association Committee on Public Health Education subsequently earmarked a sum sufficient to cover the transportation and care of exhibits and films to and from county fairs, the local county medical societies becoming responsible for the general arrangements. Through the Bureau of Exhibits of the American Medical Association, four sets of exhibit material were made available with which to begin work. Films were secured from other friends.

* * *

This Year's Experience Most Encouraging.—In spite of a late start, the experiences in this try-out year of 1941 in placing public health exhibits at district and county fairs—of which California has 52—have been most encouraging. In a previous issue, that of July, 1941, on page 1, the experience of the first display at the Tehama County Fair received comment. Since then, brief reports of other exhibits have been given in the department devoted to the activities of the Committee on Public Health Education.

Last year, the "Los Angeles Health Defense Exposition" was sponsored by the Los Angeles County Medical Association, the large project being presented to the citizens of that metropolitan center at its Shrine Auditorium. That particular effort necessitated much special planning and work. However, the experience gained proved of value to the committee of that county medical society when appeal was made that an exhibit be placed at the Los Angeles County Fair, which was held at Pomona, September 12 to 28.*

* * *

Population Areas in County Fair Districts and Attendance at Fairs.—At the State Fair at Sacramento, there was an attendance of almost 700,000, and at the Los Angeles County Fair it is expected the attendance number will probably be greater.*

In this issue will again be found the list of county fairs held in California with population of the counties in which the fairs are held.† It must be remembered that in some of the smaller counties a much larger population group is served because such fairs are more than local county institutions, being rather, "district fairs," designed to meet the needs of a group of contiguous counties.

* * *

California's Opportunities, Through Public Health Publicity Via County Fairs, Must Not Be Lost.—The medical profession will have only itself to blame if it does not avail itself of the splendid opportunities of presenting public health information under the favorable conditions which exist in the State and at many county fairs annually held in California. For, at each of these fairs, we have audiences gathered for us without any effort, composed of citizens who are in a receptive mood to be interested in worthwhile exhibits or films. Our only work is to set up the public health and educational displays in attractive and instructive manner, with representatives in attendance to answer questions, and to pass out follow-up literature.

With the experience gained in this year, 1941, it should be possible to secure much greater results in the fairs to be held next year.

* * *

Every County Medical Society Should Have a County Fair Committee.—It is important, therefore, that every county society, if it has not already done so, appoint at once a county fair committee through whose members the county fair manager may be written to, at an early date, making tentative request for space. This year, owing to lateness, when several applications were sent in, it was not possible to secure space.

If your county society has not appointed such a committee, the California Medical Association Committee on Public Health Education requests that this be done, even though it should be decided later that an exhibit may not be advisable. The Association Secretary will maintain contacts with the local committees and gladly aid in the planning of displays for 1942 which, with proper local co-operation, can bring to the medical profession returns in good will that may not be secured in any other manner and certainly not with so little effort or expense on our part.

CALIFORNIA ACCIDENT COMMISSION RESOLUTION OF OCTOBER 16, 1940: REGARDING MEDICAL RECORDS TO BE MADE AVAILABLE

Resolution of October 16, 1940.—California and Western Medicine, in its issue of December, 1940, on pages 273-276, presented the California Industrial Accident Commission's resolution, adopted October 16, 1940, concerning medical and hospital records to be made available. Because of the importance of the confidential relationship issues involved, the subject has remained under constant consideration by the California Medical Association Council. Fortunately, the State Commission did not try to put the resolution into operation, a modifying statement being issued, although the resolution of October 16, 1940, was not rescinded.

The original resolution was phrased in the following language:

(copy)

Resolution Adopted by the Members of the Industrial Accident Commission at a Meeting Held Wednesday, October 16, 1940

The Commission, having considered the problem, is of the opinion that it is necessary for the proper functioning of the Industrial Accident Commission and the prompt and proper determination of litigated cases before the Industrial Accident Commission that medical reports, x-rays, and hospital records be made available to the opposing side, regardless of whether or not a formal claim has been filed; now, therefore, be it

Resolved, That the Rules of Practice and Procedure of the Industrial Accident Commission, effective January 7,

* For additional information, see in this issue, on page 208. Attendance at Los Angeles reached a total figure of 800,253. The Los Angeles County Fair has now been given the title, "World's Biggest Annual Fair."

† For list of fairs, see page 210.

1933, be amended, effective at once by the addition of the following rule, to be identified as Section 3 of Subdivision 18, as follows:

In all cases where an industrial injury occurs, the injured employee and his authorized agents, including attending or examining physicians and attorney, shall be given access to all medical reports, hospital records, and x-rays whether in the possession of the attending or examining physicians, the employer, the hospital, or the insurance carrier, and they may make copies of the same. The employer or insurance carrier shall file promptly with the Industrial Accident Commission all reports of all physicians appointed by the employer or insurance carrier and send one copy of each of said reports to the applicant's attorney or other representative, and if there be no attorney or other representative, to the employee. Medical reports and x-rays, obtained by or on behalf of the injured employee, shall likewise be made available to the employer, or his insurance carrier. All such reports shall be filed with the Industrial Accident Commission and a copy thereof with the employer or his insurance carrier. The employer and insurance carrier and the employee shall, on request of the Industrial Accident Commission or referee thereof, file all x-rays with the Industrial Accident Commission.

* * *

It is pleasing to be able now to report to the members of the California Medical Association that the California Industrial Accident Commission, under date of September 16, 1941—eleven months after the passage of a resolution that was not and could not be enforced—saw fit, by unanimous vote, to rescind it.

The Commission's letter of transmittal appears in this issue in the Letters Department,* but for convenience of reference and cross-check, the "Resolution of September 16, 1941," which is worthy of careful study and consideration, appears below. Comment thereon may be made in subsequent issue. The foreword and text of the new "Resolution of September 16, 1941," follow:

RESOLUTION OF SEPTEMBER 16, 1941

On October 16, 1940, the Industrial Accident Commission, being of the opinion that it was necessary for the proper functioning of the Industrial Accident Commission and the prompt and proper determination of litigated cases before the Industrial Accident Commission that medical reports, x-rays, and hospital records be made available to the opposing side, adopted on said date a resolution identified as Section 3 of Subdivision 18 of the Rules of Practice and Procedure of the Industrial Accident Commission.

As the result of the experience of the Industrial Accident Commission subsequent to October 16, 1940, and further study, it is deemed advisable to rescind said rule identified as Section 3 of Subdivision 18 of the Rules of Practice and Procedure of the Industrial Accident Commission and adopt the rule set out in this resolution, to be known as Rule 19.

Resolved, That the action of the Commission in passing the rule amending the Rules of Practice and Procedure of the Industrial Accident Commission adopted by the Industrial Accident Commission October 16, 1940, and identified as Section 3 of Subdivision 18, be rescinded and set aside, effective October 1, 1941; it is further

Resolved, That the Rules of Practice and Procedure of the Industrial Accident Commission, effective January 7, 1933, be amended, effective October 1, 1941, by the addition of the following rule to be identified as Section 19 of said rule.

1. Upon the filing with the Commission by any party in interest of an application or a petition in writing, stating the general nature of any dispute or controversy concerning compensation or concerning any right or liability arising out of or incidental thereto, all parties to the application must immediately, or in any event within five days after service of the application or petition, send to the Commission copies of all medical reports of all doctors appointed by them and all other reports that they may have in their possession or under their control, relating to the dispute or controversy and send copies of such reports to the adverse party's attorney or representative, if there be one; otherwise to said party.

2. Upon order of the Industrial Accident Commission or a referee thereof, a party to the proceeding must immediately file with the Commission all x-rays in his possession or under his control. Upon request of the adverse parties, x-rays shall be made available to physicians designated by them.

3. All parties and their representatives shall be given the opportunity to examine hospital records in all cases mentioned in Section 1 of this rule and be permitted to make copies of all or any part of such records.

4. All reports acquired by any of the parties subsequent to the time specified in Section 1 of this rule shall immediately, and in any event within five days after receiving them, be sent to the Industrial Accident Commission and copies served upon the adverse party's attorney or representative, if there be one; otherwise to said party.

5. If a party fails or refuses to comply with these rules, the Commission or a referee may decline to receive in evidence any medical report or other written testimony from a physician whose report has not been so filed and it shall be presumed that the report or evidence was willfully suppressed and would be adverse if produced.

6. In the case of willful refusal or failure to comply with the requirements of this rule on the part of any attorney or representative of such party in proceedings before this Commission, the Commission may consider such failure or refusal good cause for the removal, denial or suspension of the privilege of any such attorney or representative to appear as such attorney or representative in proceedings before the Industrial Accident Commission after notice and opportunity to be heard.

7. Willful refusal or failure to comply with the requirements of this rule will be deemed to be an act of contempt for which the offending party, attorney, agent or representative, or any of them, may be punished by the Commission after notice and opportunity to be heard.

8. The penalties provided in this rule are cumulative and shall not impair or interfere with the power of the Commission to enforce any or all pertinent sections of the Labor Code or the statutes of this state.

* See page 222.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 206.

EDITORIAL COMMENT†

SECONDARY IMMUNOLOGIC CYCLE IN PNEUMONIA

Isolation and identification of the acute-phase reactive protein of pneumonic blood are currently reported by Abernethy, Avery,[1] and MacLeod[2] of the Rockefeller Institute. Determination of the chemical nature of this acute-phase precipitin goes far to settle numerous controversial questions in theoretical immunology and practical clinical medicine.

Biochemical analyses of the pneumococcus led to the early recognition of two fractional antigens of major clinical interest: "Fraction A," a type-

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

1 Abernethy, Theodore J., and Avery, Oswald, T.: Jour. Exp. Med., 73:173 (Feb.), 1941.

2 MacLeod, Colin M., and Avery, Oswald, T.: Jour. Exp. Med., 73:183, 191 (Feb.), 1941.

specific capsular polysaccharide, and "Fraction B," a somatic nucleoprotein which is not type-specific. Ten years ago, Tillet and Francis[3] described a third antigenic component which they designated as "Fraction C." This new antigenic fraction is conctostable, and is readily extracted from semi-autolyzed pneumococci by repeated boiling in slightly acidulated sodium chlorid solution. The "C fraction" is highly reactive with pneumonic antiserum, often giving precipitin reactions in dilution as high as 1 : 1,000,000.

Tillet and Francis found that, in noncomplicated cases of lobar pneumonia, antibodies are formed independently of each other against the three antigenic fractions. Anti-A precipitins and agglutinins, for example, are usually not demonstrable till the sixth day of the infection, and usually increase in titer till the fourteenth day, after which they undergo a slight decrease in titer. Anti-B precipitins, in contrast, are usually demonstrable as early as the third day of the disease, and are maintained at a fairly high level throughout convalescence. In marked contrast with the response to these two antigenics, anti-C precipitins are usually demonstrable in highest titer within eighteen hours after the onset of febrile symptoms, are maintained at this high level till the onset of crisis, and usually decrease precipitously in titer with the fall in body temperature. Anti-C precipitins usually completely disappear from the pneumonic circulation in from one to three days after the crisis.

A possible interpretation of this explosive rise and fall of C-precipitins was suggested by the so-called "anamnestic reaction" of Cole,[4] who found that in animals which have previously been immunized against certain bacteria and in which specific antibodies have completely disappeared from the circulation, an explosive liberation of latent or stored antibodies takes place on a subsequent inoculation with the same infectious agent. This plausible explanation, however, was soon rendered improbable by the discovery[5] that "C-reactive substances" (or anti-C precipitins) are demonstrable in the serums of infants, presumably at the time of their first clinical contact with the pneumococci. The C-precipitins are also demonstrable in numerous other infectious diseases, including infections with both Gram-positive and Gram-negative bacilli.

Interpretation of the C-precipitin was rendered still more difficult by the discovery[6] of the presumptive allergic rôle of this reactive factor. During the acute stage of pneumonia, for example, a characteristic delayed skin reaction to C-carbohydrate is demonstrable, closely correlated in severity with the anti-C precipitin titer. In all patients in whom the disease terminates in uneventful recovery, both serum titer and allergic skin reactions become negative shortly after the crisis. In complicated cases both may persist or reappear. It was subsequently found[7] that an analogous acute phase C-precipitin can be demonstrated in the serums of experimentally infected monkeys, which often yield acute stage serums which precipitate C-pneumocarbohydrate in dilutions as high as 1 : 500,000. The "reactive substance" is demonstrable in rhesus serums as early as twenty-four hours after experimental inoculation, but disappears quantitatively with the approach of convalescence.

The Rockefeller Institute clinicians found that in both man and monkeys C-reacting substance is relatively thermostable, and will resist heating to 60 degrees centigrade for thirty minutes, the usual temperature of complement inactivation. On fractionation of a pneumonic serum the C-reacting factor is an albumin, and is found quantitatively in the serum fraction which is precipitable by between 50 to 75 per cent saturation with sodium or ammonium sulfate. The substance, therefore, is presumably not a conventional antibody, most of which are found almost exclusively in the globulin fraction. As a still greater surprise, the C-reactive protein is completely inactivated by the removal of calcium, and can be reactivated quantitatively by its restoration. Ordinary antibodies are not conditioned by the presence or absence of calcium. The reactive protein can be readily separated from normal serum albumins, due to its insolubility in tap water (or in distilled water containing a trace of calcium). By repeated salting out and dialysis against calcified water, the C-reactive protein can be isolated in a state of at least approximate chemical purity.

Injected into rabbits, this reactive albumin stimulates the production of an anti-reactive precipitin, by means of which minute traces of C-reactive protein can be accurately titrated in human serum, in various body fluids, and in the presence of other tissue products. Studied by means of this rabbit precipitin, the C-reacting albumin is found to be antigenically distinct from the normal serum albumins. In both man and monkeys, therefore, the C-reacting albumin is an alien colloid, and is presumably auto-antigenic.

The work of the Rockefeller Institute biochemists is of wide clinical interest, due to the large number of similar adjuvant or secondary immunochemical cycles already demonstrated in virus diseases. It was shown as early as 1933, by Hughes,[8] for example, that in yellow fever an abnormal acute-phase albumin is demonstrable in both the human and rhesus circulation, that this acute-phase albumin is auto-antigenic, and is destroyed or removed quantitatively during convalescence, as a result of the action of a secondary precipitin. These secondary precipitins apparently have little or no specific protective functions. Similar acute-phase proteins and secondary precipitins have been demonstrated in vaccinia,[9] influenza,[10] myxomatosis,[11] and, more recently, in lymphocytic choriomeningitis.[12] Demonstration of a presumptive secondary auto-immunological cycle in the simpler

3 Tillet, William S., and Francis, Thomas: Jour. Exp. Med., 52:561, 1930.
4 Cole, R.: Zeitsch. f. Hyg., 46:371, 1904.
5 Ash, Rachel: Jour. Infect. Dis., 53:89, 1933.
6 Abernethy, T. J., and Francis, T., Jr.: Jour. Exp. Med., 65:59, 1937.
7 Abernethy, T. J.: Jour. Exp. Med., 65:75, 1937.
8 Hughes, T. P.: Jour. Immunol., 25:275, 1933.
9 Craigie, J., and Wishart, F. O.: Tr. Roy. Soc. Canada, Section V, 29:57, 1935.
10 Hoyle, L., and Fairbrother, R. W.: Jour. Hyg., 37:512, 1937.
11 Rivers, T. M., Ward, S. M., and Smadel, J. E.: Jour. Exp. Med., 66:1, 1937; 69:31, 1939; 72:129, 1940.
12 Smadel, J. E., Baird, R. D., and Wall, M. J.: Jour. Exp. Med., 70:53, 1939; 71:43, 72:389, 1940.

bacterial infections, therefore, may well mark the opening of a new epoch in practical immunochemical research.

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RHEUMATIC HEART DISEASE

III*

A journey of a thousand miles begins with a single step. Years ago medicine took the first step along the tortuous trail toward the control of tuberculosis by making that disease reportable, by ascertaining its true dimensions. The knowledge collected by the simple means of making tuberculosis reportable in that hard-fought and effective preventive campaign was of inestimable value, and the results well known.

We know now that we might be twenty years ahead of ourselves in the control of rheumatic heart disease today if that, too, had been made reportable years ago. We know that by applying to rheumatic heart disease what we have learned from the fight against tuberculosis we can bring that disease under control—perhaps within two decades.

But we must take the first step first. We cannot begin the long journey until we have made the disease reportable.

Members of the California Medical Association who are also members of the California Heart Association as well as public health authorities throughout the State are asking that this be done. Recently the California Heart Association unanimously requested the State Board of Health to make rheumatic heart disease reportable.†

If and when that is done California physicians are urged to report the disease according to etiology. School nurses and teachers must be taught to be on the alert for the more easily detectable evidences of rheumatic infection and to report cases to the school physician for future examination.

We know from our experience with tuberculosis that a preventive campaign cannot be run from an armchair. On the clinicians, who always "carry the ball," will depend the ultimate success of this most vital health defense effort.

University of California Hospital.

Amos Christie,
San Francisco.

BITTNER'S MURINE CARCINOGENIC VIRUS

Bittner's latest conclusion,[1] that the disease currently classified as spontaneous breast cancer in mice is, in reality, a virus infection, may go far to correct certain unfortunate popular misconceptions that have arisen from his earlier description of a mysterious carcinogenic "influence" in normal milk.

For a number of years the staff members of the Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Maine, have made genetic studies of numerous intensively inbred strains of mice. Under natural methods of propagation, these strains showed widely different hereditary tendencies to develop spontaneous breast tumors. At one end of the scale there were certain strains, 95 per cent of whose members eventually died of mammary carcinoma. At the other extreme there were murine strains in which the incidence of spontaneous breast tumor was as low as 0.5 per cent.

About 1933 the routine method of propagation was purposefully or inadvertently altered, many of the young being reared by foster mothers. It was then noted[2] that the fostered young tended to acquire the carcinogenic percentage of the foster mothers. Thus, a highly susceptible (94.9 per cent) mouse strain was changed to a highly refractory (0.7 per cent susceptible) strain as a result of refractory (0.5 per cent) breast feeding, while highly refractory (0.5 per cent susceptible) strains became highly susceptible (89.8 per cent) as a result of reciprocal feeding.

Seven years' study of the milk-borne carcinogenic (or anti-carcinogen) "influence" thus suggested[3] has shown that the apparent modifications in her dietary percentages, are not due to a protective antibody in noncarcinophilic milk, but to a toxic factor in carcinophilic milk. This carcinogenic toxin was first pictured by Bittner as a catalyst, capable of absorption from the gastrointestinal tract, and of multiplying (or being multiplied) as an ingrafted enzyme in the tissues of fostered young in much the same way that phlage is multiplied by bacteria. He found that the carcinogenic enzyme is present in carcinophilic milk during the entire lactation period, and is afterward demonstrable in aqueous extracts of the spleen, thymus and other tissues of the fostered young.

Adequate confirmations of these findings have been reported by other investigators.[4] Significant modifications in the technique were afterward made by Law[5] and Cloudman.[6] Law, for example, found that the milk-borne carcinogenic "catalyst" also increases murine susceptibility to experimental inoculation with mouse leukemic cells. As a result of foster feeding, hereditarily resistant strains acquire a 100 per cent leukemic susceptibility.

Several years ago, two new artificial strains of mice were produced in the Bar Harbor Laboratory by transferring fertilized ova of cancer-resistant mice into the pregnant uteri of cancer-susceptible hosts, and vice versa. These two artificial hybrid strains have been intensively inbred since that time. Cloudman has recently tested their relative susceptibility or immunity by experimental inoculation with mouse sarcoma cells. His data suggest an acquired susceptibility resulting from transplan-

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* For Articles I and II of this series, see issues of August (page 58) and September (page 117).

† Christie, A.: Concerning Rheumatic Heart Disease, Calif. and West. Med., 55:109 (Aug.), 1941.
Christie, A.: More Concerning Rheumatic Heart Disease, Calif. and West. Med., 55:117 (Sept.), 1941.

1 Bittner, John J.: Science, 93:527 (May 30), 1941.

2 Staff, Jackson Memorial Laboratory: Science, 78:465, 1933.

3 Bittner, John J.: Amer. Jour. Cancer, 39:104 (May), 1940.

4 Andervout, H. B., and McEleney, W. J.: Publ. Health Rep., 53:777, 54:1597, 1939. Korteweb, R., and Snell, G. D.: Third Internat. Cancer Congress, 1939.

5 Law, Lloyd W.: Science, 93:381 (April 18), 1941.

6 Cloudman, Arthur M.: Science, 93:380 (April 18), 1941.

tation of ancestral resistant ova into a susceptible host, which acquired susceptibility has been propagated with little or no change for at least ten nonfostered generations.

Conservative biologists, firm believers in classical Mendelian theory, have been inclined to interpret the Bar Harbor experiments as evidence of the existence of a milk-borne (or placentally transferred) carcinogenic virus. That this interpretation is correct is currently alleged by Bittner,[1] who was able to demonstrate the carcinogenic "influence" in filtrates from lyophilized murine breast cancer. Ten young mice of a cancer-resistant stock were each allowed to drink about two cubic centimeters of this filtrate. Six of them developed apparently spontaneous breast cancer by the end of 12.4 months. None of the brother and sister controls not given the lyophilized filtrate have thus far developed breast tumors.

There is nothing inherently improbable in Bittner's conclusion, that so-called spontaneous breast cancer in certain intensively inbred strains of mice is, in reality, a milk-borne virus infection. It is well known that several presumptive cancers in lower animals are virus infections. It is also known that the causative agent in breast infections is often given off in the milk. Certain ultramicroscopic viruses are known to be capable of absorption from the gastro-intestinal tract, and of subsequently localizing in other tissues. Thus localized, murine viruses may remain latent, manifesting their presence only after supplementary tissue injury.

Proof of the virus nature of Bittner's milk-borne carcinogen, however, is thus far based solely on its resistance to the lyophilized filtrate technique. The evidence, therefore, is far from being complete. For the present, Bittner's conclusion must be regarded as little more than a plausible working hypothesis, a promising basis for future experimental study.

Mice are notoriously susceptible to subpathogenic viruses, which cannot be transferred to higher animal species. Hence, there is no reason to suspect that Bittner's work is at all applicable to clinical medicine or to the dairy industry. Until unpasteurized mouse milk becomes a product of commercial interest, his work is of purely theoretic interest. Tests of human and dairy milks by the Bittner technique, of the effects of pasteurization on his hypothetical murine virus, and of its possible antigenicity for rabbits and other higher animals, are now in progress.

Law's[7] latest discovery, that in certain inbred mouse strains repeated injections of 2.5 milligrams dose of sodium desoxycholate (total dose 10 milligrams) during infancy will lead to a significant (threefold) increase in the incidence of spontaneous pulmonary tumors in late adult life, suggests a quite different interpretation of Bittner's experimental evidence. Whether or not similar bile derivatives are present in murine carcinophilic milk, however, and whether or not, if present, they are equally effective on oral administration, have not yet been determined.

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7 Law, L. W.: Proc. Soc. Exper. Biol. and Med., 47:37 (May), 1941.

MYOSITIS

There is a great deal of controversy concerning the clinical importance of myositis. On the continent most physicians are wont to feel that myositis is a disease which is frequently encountered in practice. In this country there are many who contend that this disease is extremely rare and that it is present only in such definite affections as trichinosis. The latter group of physicians are of the opinion that muscular pains in the back and in the extremities are caused by muscle spasm secondary to local joint disease. They believe that referred pain, also originating in joint lesions, account for many muscle pains. The American school of thought has much in its favor since the pathologic changes of myositis have rarely been described.

It is difficult to believe that the skeletal muscular system, which comprises 40 per cent of the human body weight, should be so resistant to disease processes. Of late, evidence has been accumulating in this country to substantiate the frequency of myositis. Geschickter [1] has described the lesion pathologically. Bodanski [2] found a reversal of the normal creatin urinary ratio in a case of diffuse myositis. Steindler [3] has described his novocain test for the differentiation of superficial pain (presumably caused by myositis) from the deeper joint pain of arthritis. A simpler method of differentiation is that described by Lewis,[4] and others. The painful muscular area is palpated with one finger. If tenderness is elicited, one presumes the origin of the pain to be local, in the muscles. If no tenderness is obtained, one assumes the pain to be radiating from some other source, probably a diseased joint. Pain arising from muscle spasm may be eliminated by examination of the joint in as relaxed position as possible. Recumbency for a few moments may accomplish such relaxation.

Sufficient evidence of changes in skeletal muscle, significant of myositis, is still lacking. If such changes could be induced in animals, it should prove of value in clarifying this problem. The author has been investigating the creatin and phosphate content of chilled as compared to normal rabbit skeletal muscle. Unfortunately, no conclusive data were obtained.

At the present time myositis and fibrositis should be considered as a diagnostic possibility when examining a patient with a painful back or extremity. Clinical and laboratory evidence, which gave credence to the diagnosis of myositis, are increasing.

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ORIGINAL ARTICLES

SURGERY OF THE STOMACH AND DUODENUM*

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IN this presentation of the surgical treatment of lesions of the stomach and duodenum, owing to the time element involved, one of necessity must confine oneself to those lesions occurring most frequently, such as malignant lesions of the stomach, for the most part cancer, and benign ulcers of the stomach and duodenum. Even under these circumstances only the broader aspects of each can be discussed. For these reasons I shall present these subjects largely as they have been a part of the diagnosis and treatment by my colleagues and myself.

MALIGNANT LESIONS OF THE STOMACH

For the last two years detailed studies have been carried out in all cases with a diagnosis of malignant lesion of the stomach in which operation was performed at the Mayo Clinic from the year 1907 to 1938, inclusive. These studies have brought forth a great deal of important information substantiating, in many instances, clinical impressions which had developed over a period of years. I shall refer briefly to some of the most important.

Although it is rather difficult to classify the symptomatic picture presented by patients who had cancer of the stomach, it is an interesting commentary that approximately a third of the patients whose lesions were resectable had symptoms of the so-called ulcer type of dyspepsia and in practically the same proportion this ulcerous type of symptom complex appeared as the first symptom. Of even greater importance was the fact that when patients who had this ulcerous type of history were placed on an ulcer regimen 80 per cent had a temporary effective response with relief of pain, suggesting, therefore, a benign ulceration.

A little more than half of the patients presented what is commonly described as the usual picture of cancer of the stomach which refers to a symptom complex in which dyspepsia, associated with various degrees of disturbance of gastric motility and various degrees of decline, was present.

Roentgenologic Diagnosis.

On many occasions, I have emphasized the point that the roentgenologist has been of the greatest assistance to the internist and the surgeon in localizing gastro-intestinal lesions. The modern developments in the field of diagnosis, particularly roentgenologic, of lesions of the stomach and duodenum have decreased the possible error in failing to demonstrate lesions in a low percentage of cases and, when added to this is the opportunity to subject to gastroscopy patients who are believed to have gastric lesions, which fail to show in the roentgenogram, this incidence of possible error is reduced further to a marked degree. I have seen cases in which the roentgenologist was able to demonstrate gastric lesions no larger than one's fingernail. This is a great achievement because it enables one to recognize small lesions early, and early recognition is one of the ways in which better results will be obtained in the surgical treatment of gastric neoplasms. The fact remains, however, that there are some cases in which the roentgenologist is unable to determine whether the gastric lesion is benign or malignant, the roentgenologist's report being "gastric ulcer." It is in this group of cases that enthusiastic advocates of a routine course of medical therapy may delay operation to a time when extension or metastasis makes removal of localized malignant ulcerating lesions impossible.

In 1939, in 131 cases in which gastric resection was performed for malignant lesions of the stomach, the roentgenologist reported "malignant lesion of the stomach" in 109 cases, or 83 per cent. In approximately 10 per cent of the cases the gastric lesion was reported as "ulcer or ulcerating lesion, probably malignant" or as "ulcerating lesion, malignancy not ruled out." However, in approximately 7 per cent of the cases the report was of "gastric ulcer." In three of the nine cases in which the lesion was reported as "gastric ulcer" there was a malignant lesion of grade 4, in three cases of grade 3, in one case of grade 1, and in two cases grading was not done. In the 1907-1938 series, 10 per cent of the carcinomas were reported as gastric ulcers and 1 per cent as benign lesions.

Resectability.

In many instances roentgenologists at the clinic have attempted to progress even further in their efforts to aid the clinician and have expressed an opinion as to the operability of the lesions which they see roentgenologically. Of the cases in which roentgenologists had arrived at a diagnosis of operable malignant disease, the lesions in 48 per cent were removed. In a greater percentage of cases than this the lesions actually might have been removed, but direct extension of the neoplasm to adjacent vulnerable structures or the presence of nonremovable metastatic growths within the abdomen and apart from the stomach, conditions roentgenologists could not visualize, made radical removal inadvisable.

Of the cases in which operation was performed, in which roentgenologists considered the lesions to be inoperable or of doubtful operability, the lesions in 20 per cent proved to be removable. Conversely, of the carcinomatous lesions which at operation proved to be removable, 11 per cent had been considered by the roentgenologists to be inoperable or of doubtful operability. It must be emphasized that these percentages pertain to the series of cases being considered herein, namely, the cases of carcinoma in which the patients were operated on. In most of the cases in which the roentgenologist considered the lesions to be frankly inoperable, the patients did not undergo surgical exploration. In recent years, however, the percentage of patients

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who have been subjected to exploratory operation for carcinoma of the stomach has increased progressively, as the rate of resectability has increased. This increase in rate of operability has been due to the recognition that a definite percentage of those lesions reported to be inoperable are found at operation to be operable and in the rate of resectability because of willingness to remove, if possible, every malignant gastric lesion that has not metastasized to irremovable regions.

Treatment and Results.

Fifty-eight per cent of the 11,000 patients for whom diagnosis of malignant lesion of the stomach was made at the clinic between the years 1907 and 1938, inclusive, were subjected to surgical exploration in the hope that removal of the lesion would be found possible. In 45 per cent of this group of cases which is 26 per cent of the original total group in which the diagnosis of malignant gastric lesion had been made the lesions proved to be removable. It is interesting to compare this result with the management of malignant lesions of the stomach during 1939, during which time 66 per cent of the patients were operated on, the lesions in 43 per cent of the cases being removed. Of the total group of patients for whom the diagnosis of malignant gastric lesion was made at the clinic in 1939, 28 per cent had lesions which proved to be removable. In 1940, 260 patients (approximately 53 per cent of those for whom diagnosis was made) who had malignant lesions of the stomach were operated on; in 117 (45 per cent of the cases) partial gastrectomy was performed and in eight total gastrectomy was performed.

The average mortality rate for the 1907-1938 series of cases in which resection was done was 16 per cent. The mortality rate in 1939 for the 131 cases in which some form of resection was performed* was 11.5 per cent, and in 125 resections for malignant lesions in 1940 the mortality rate was 8.8 per cent (in eight of these cases total gastrectomy was performed). In thirty-three cases in which operation was performed for cancer of the stomach in 1939, because the lesions were irremovable, palliative operations, such as gastro-enterostomy, were performed with a hospital mortality rate of 12.1 per cent. This mortality rate emphasizes the high risk of palliative procedures for irremovable malignant lesions and, I believe, points to the need of conservatism in the employment of such conservative and palliative procedures, unless the lesion is producing almost complete obstruction, a condition which necessitates surgical intervention in order to enable the patient to leave the hospital and return home.

Survival rates.—The five-year survival rate for those patients who underwent resection is 29 per cent, and when this rate is adjusted for the normal death rate it is 32 per cent. The ten-year survival rate is 20 per cent, and when it is adjusted for the normal death rate, it is 25 per cent. The fifteen-year survival rate is 15.2 per cent;* twenty-year, 10.5 per cent; and the twenty-five year rate, 6.3 per cent.

Survival rate in relation to degree of malignancy.—Broders' index of malignancy for many years has been a most acceptable measuring stick and its accuracy is borne out in the present study, for in the five-year survivals after resection 86.2 per cent of patients who had lesions of grade 1 lived five years or more after leaving the hospital, 58.8 per cent who had lesions of grade 2, 30.2 per cent of grade 3, and 23.3 per cent of grade 4.

Survival rate according to metastasis and extension.—In cases of 1,951 patients who underwent resection the factors of metastasis and extension were studied to determine their effect on the prognosis. In cases with no extension or metastasis, 44.7 per cent of the patients lived five years after leaving the hospital. When there was direct extension of the lesion to adjacent tissue which was removed with the lesion, 39.1 per cent of the patients lived five years. When metastasis was present, 17.3 per cent lived five years. When metastasis and direct extension were present, 17.1 per cent lived five years.

Survival rate as related to age.—It is commonly believed that malignant lesions as they occur among younger patients are more fulminating than those which afflict older persons and that, therefore, the results of treatment of carcinoma among younger persons are considerably poorer than the results obtained for patients in the older age groups. In this study the five-year survival rate was calculated according to the age of the patient at the time of operation, and it was found that for patients less than forty years of age the survival rate was 25.1 per cent (26 per cent when adjusted for normal death rate), in contrast to the survival rate of 29.7 per cent for patients from forty to forty-nine years of age (31.2 per cent when adjusted for normal death rate); the five-year survival rate of patients fifty to fifty-nine years of age was 29.2 per cent (32.2 per cent when adjusted for normal death rate), 28.9 per cent for patients sixty to sixty-nine years of age (35.8 per cent when adjusted for normal death rate) and 29.8 per cent for patients seventy years or older (49.3 per cent when adjusted for normal death rate).

The hospital mortality rate for younger patients was considerably lower than for older patients. Among the twenty-four patients in the age group from twenty through twenty-nine years who underwent resection no deaths occurred. The mortality rate among 183 patients in the age group from thirty through thirty-nine years was 5 per cent and among 563 patients between forty and forty-nine years it was 10 per cent. In the age group from fifty years upward, the mortality rate increased progressively by decades, being 24 per cent among 179 patients aged seventy years or more. The average mortality rate in the 2,772 cases of resection for carcinoma of the stomach for all age groups was 16 per cent. Therefore, in a consideration of those patients between thirty and thirty-nine years

* One hundred and twenty-five cases of partial gastrectomy, four of total gastrectomy, and two of local exeision. The mortality rate for the 125 cases of partial gastrectomy was 10.4 per cent.

* Survival rate beyond ten years approaches that of the normal population.

of age who undergo surgical exploration for carcinoma, the chance for a five-year cure is about the same as it would be for patients of older ages, provided, of course, that the lesion is operable and is removed.

Sarcoma of the Stomach.

The discussion thus far has taken into consideration all malignant lesions of the stomach. It might be of interest, however, to call attention to the fact that in the series of patients (6,352 patients) who were operated on for malignant lesions of the stomach, in 110 cases, or 1.7 per cent, the lesions were sarcoma. Of this number, sixty-eight resections were performed with a mortality rate of 13.2 per cent, whereas palliative operations were performed in seven cases with a mortality rate of 14.3 per cent. These mortality rates closely approximate those for carcinoma, but the interesting difference between sarcoma and carcinoma is apparent in the distribution according to age and sex, for 24.5 per cent of the patients who had sarcoma were less than forty years of age, whereas but 6.9 per cent of those who had carcinoma of the stomach were less than forty years of age.

GASTRIC ULCER

In 1940, 106 (approximately 48 per cent) of those patients for whom a diagnosis of gastric ulcer was made were operated on.

Experience has shown that in the evolution of treatment, cycles occur. This phenomenon may be due to the changing incidence of the disease or to its severity. Of great influence, of course, are the results which follow different methods of treatment. Generally speaking, response to conservative methods of treatment is more likely to occur when economic and social changes have improved the general health of the community. Under such circumstances, routine methods of therapy may produce an increasing incidence of benefit or cure, which increases further when improved methods of therapy are developed and instituted.

These remarks apply particularly well to the treatment of gastric ulcer. As a result of a better understanding of this lesion and its earlier recognition, while the lesion is still small and without the complicating features of hemorrhage, perforation and obstruction, relief of symptoms and healing of the ulcer have resulted from a medical regimen in more cases recently than many years ago. The only objection to a medical regimen in all such cases is that in some of them the lesion, instead of being a small gastric ulcer, is in reality an ulcerating carcinoma. In many such cases roentgenologic or gastroscopic examinations will not assist in the differential diagnosis. It has been said that a trial course of medical treatment serves as a diagnostic aid, for, if the patient is relieved of symptoms, if roentgenographic examination demonstrates that the ulcer has disappeared, and if blood disappears from the stools, then the lesion is benign. Clinical experience, however, has demonstrated that in some cases of malignant gastric ulceration these criteria may seem to be satisfied but that the lesion does not heal; it only seems to do so, for, as Schindler has shown, the carcinomatous process may extend from the margin of the ulcer into the crater, obliterating it.

The incidence of malignant changes in gastric ulcers has been stated to be from 10 to 20 per cent. Walton said that the figures of Stewart now are generally accepted. He concluded that in 9.5 per cent of cases chronic ulcer becomes carcinomatous and that carcinoma originates in a chronic ulcer in 17 per cent. Katsch, however, reported an incidence of 20 per cent. Finsterer found that in 532 cases of resection for gastric ulcer the ulcer was carcinomatous in 141, an incidence of "20.9 per cent."

The possibility of healing a large gastric ulcer with a crater 1.5 centimeter or more in diameter by other than surgical methods should be looked on with skepticism, for all such ulcers have a tendency to perforate. Patients who have such lesions usually have had clinical evidence of perforation of the ulcer either to the gastrohepatic omentum or to the pancreas, and many of them have had hemorrhages. When such lesions occur, surgical removal of the lesion affords the best chance of permanent cure and does it in a reasonably short time. This statement is true regardless of the age of the patient if his condition is otherwise satisfactory. Furthermore, surgical removal relieves the menace of fatal hemorrhage from the lesion or of an acute perforation which may require an emergency procedure for its closure. Of great importance is the removal of a lesion which may be malignant or may become so.

The risk of the operation for gastric ulcer should not exceed a maximum of 5 per cent, and it is possible to operate on a large series of patients who have gastric ulcer with a mortality rate of considerably less than 5 per cent. In point of fact, in 278 cases in which partial gastrectomy was performed at the Mayo Clinic in 1939 for benign ulcers of the stomach or duodenum, the mortality rate was 4 per cent. Partial gastrectomy for gastric ulcer was performed in eighty-nine cases with a mortality rate of 2.2 per cent. In 1940, partial gastrectomy for gastric ulcer was performed in eighty-eight cases with one death; excision or gastro-enterostomy, or both, were performed in seventeen cases with no death. The cases were selected carefully, and partial gastrectomy was performed only when the nature of the lesion and the condition of the patient warranted this procedure. The results of a properly chosen, properly performed operation for gastric ulcer are some of the best in surgical practice, for recurrence of the ulceration is rare. I have not seen recurrence of gastric ulcer or gastrojejunal ulcer after partial gastrectomy for gastric ulcer when half or more of the stomach has been removed. Recurrence of ulcer, in my experience, is rare when the gastric ulcer has been excised and gastro-enterostomy performed.

In the experience of the clinic the large gastric ulcers are most frequently present along the lesser curvature of the stomach or slightly posterior to it. On reviewing 272 cases of chronic gastric ulcer in which operation was performed at the Mayo

Clinic from January 1, 1933, to December 31, 1936, inclusive, Clagett and I [28] found that 66.9 per cent of the ulcers were at or above the incisura angularis, 15 per cent were on the posterior wall and 1.5 per cent were on the greater curvature. The remainder were below the incisura angularis.

In several of the cases at the clinic the ulcer appeared, on roentgenologic examination, to be located very high on the lesser curvature, and for this reason it was thought that operative removal would be difficult; it was found at operation, however, that perforation of the lesion to the capsule of the pancreas had given an erroneous idea of the amount of the stomach between the ulcer and the esophagus. In these cases there was actually much more uninvolved stomach than the roentgenogram indicated. On other occasions the early division of the gastrohepatic omentum at a very high level assisted in mobilizing the upper part of the stomach so that unusually high lesions could be removed without too great difficulty. Two observations led me to study a series of patients operated on for benign and malignant lesions situated midway between the incisura angularis and the esophagus or higher. These were as follows: (1) Recognition of the fact that the roentgenologic appearance of a gastric ulcer can be so misinterpreted that necessary surgical procedures may be postponed; and (2) a general impression that, although removal of a gastric ulcer is made more difficult when it is situated above the incisura angularis, the mortality rate from the operation is not increased appreciably.

During 1938 and 1939 at the Mayo Clinic there were forty-two cases in which operation was performed for benign lesions situated in the cardial region of the stomach, with one death, a mortality of 2.4 per cent. Thirty-five patients who had cardial benign gastric ulcers were operated on. In twenty-six cases partial gastrectomy was done for cardial gastric ulcer, with one death, a mortality of 3.8 per cent. In four cases the ulcer was excised, and gastro-enterostomy was performed. In one case excision of the ulcer was done, and in four cases gastro-enterostomy was performed. In these nine cases there were no deaths. In three the lesions removed were polyps; in two, diverticula; in one, a leiomyoma, and in one, a cyst. Local excisions were performed in six of these seven cases, and partial gastrectomy was performed in one. There were no deaths.*

I have referred to these cardial ulcers because frequently I have seen patients with such lesions in whom the excuse for a course of medical treatment, even though the lesion was large and in many cases had been complicated by hemorrhage, was that the lesion was probably located too high to be removed safely. The fallacy of this opinion is borne out not only by the fact which has been brought out, namely, that the lesions appear roentgenographically to be higher than they really are, but in a group of cases in which such lesions were removed surgically, the operative mortality was only slightly higher than that for similar operations for gastric ulcer located at the lower levels on the lesser curvature or the body of the stomach.

There are several satisfactory procedures that may be employed in the surgical treatment of gastric ulcer. The procedure of choice is partial gastrectomy with removal of the lesion. The advantages of this procedure are the removal of the lesion with its possible hemorrhage, perforation or malignant degeneration, riddance of associated pylorospasm and induction of a high incidence of relative achlorhydria with almost total absence of gastrojejunal ulceration. The Polya type of end-to-side anastomosis posterior to the colon is utilized most frequently. If the lesion should prove, on microscopic examination, to be malignant, its removal by partial gastrectomy gives the patient the best chance of cure, for the procedure removes the lymphatic regions in the excised portion of the gastric wall and in the adjacent gastrocolic and gastrohepatic omenta, which might harbor malignant cells that extended from the original lesion.

Study was made of the results in the 272 consecutive cases of gastric ulcer for which operation was performed at the clinic; partial gastrectomy was performed in 162 of these cases. Although the operation of partial gastrectomy for gastric ulcer gives almost uniformly good results without recurrence of ulceration, when partial gastrectomy cannot be safely utilized, on account of the poor general condition of the patient or the nature of the lesion itself, surprisingly good results may be obtained by less radical methods, such as excision of the ulcer with gastro-enterostomy or occasionally excision of the ulcer alone.

DUODENAL ULCER

During 1939, 2,729 patients who had duodenal ulcer were examined at the clinic and operation was performed in 467, or 17.1 per cent of the cases. In 1940,[33] at the clinic 13 per cent of the patients with duodenal ulcer were operated on.

In 1936, before the meeting of the Western Surgical Association, I [25] presented a paper on the topic, "Should Gastric Resection Be Done for Duodenal Ulcer?" At that time I called attention to the fact that, although it had been the custom in the Mayo Clinic as early as 1905 to perform partial gastrectomy in the treatment of large, calloused gastric ulcer, because of the possibility of the lesion being malignant, the more conservative procedures of gastro-enterostomy or excision of duodenal ulcer, with plastic operations involving the lower portion of the stomach and the duodenum, had been the surgical procedures of choice for patients having duodenal ulcer who had failed to obtain relief of symptoms on a medical regimen. Since that time an increased percentage of patients operated on for duodenal ulcer has undergone partial gastrectomy, and an attempt has been made to formulate a definite opinion of the indications for and against the operation.

* In thirty-four cases in which cardial carcinoma was present, surgical treatment was possible. In all but one, gastric resection was performed; that is, partial gastrectomy in twenty-eight and total gastrectomy in five. In these thirty-four cases the mortality rate was 14.7 per cent. The mortality rate for operations for malignant disease in the upper part of the stomach is in keeping with that following partial gastrectomy performed for all types of carcinomas of the stomach in the year 1938 [32] at the clinic, which was 12.5 per cent (126 cases).

In 1940, partial gastrectomy was performed in 140 cases for duodenal ulcer and gastro-enterostomy in 203 cases. In order to discuss the rationale of the development of partial gastrectomy in the treatment of duodenal ulcer it will be worth while to refer briefly to some of the principles involved in usage.

Gastrojejunal Ulceration.

In the early 1920's, Lorenz and Finsterer gave as their main reason for advocating gastric resection for duodenal ulcer, that the procedure was followed by reduction in incidence of gastrojejunal ulcer to one per cent or less, in contrast to an incidence of at least 10 per cent, reported by Lorenz,[15] subsequent to gastro-enterostomy performed in Austria. The reason for this reduction in the occurrence of gastrojejunal ulcer was stated to be that achlorhydria occurred subsequent to gastric resection and hence recurring gastrojejunal ulceration could not take place. However, since the risk of partial gastrectomy was greater than that of gastro-enterostomy, and since in partial gastrectomy the considerable part of the stomach which was removed usually did not give evidence when examined by the pathologist of the marked degree of gastritis present in cases reported in Germany; and, further, since the conservative operations of gastro-enterostomy had been followed in many clinics by an incidence of recurrent ulceration of not more than 4 per cent, little enthusiasm was aroused in the United States for partial gastrectomy in the treatment of duodenal ulcer. There were, however, two groups of surgeons in two separate regions of the United States, who had adopted the procedure. The surgeons in these groups had adopted it because, in their experience, a relatively high incidence of gastrojejunal ulceration occurred subsequent to more conservative procedures.[13,14] Their patients were, for the most part, of one race, in which the percentage of intermarriage is exceedingly high. In the years that followed, largely as a result of the interest of these two groups of men who, in their experience, had been able to reduce the incidence of gastrojejunal ulcer in their cases to 3.1 per cent [3] as a result of the adoption of partial resection for duodenal ulcer, increasing interest in partial gastrectomy for duodenal ulcer appeared.

With the accumulation of larger series of cases in which partial gastrectomy had been performed for duodenal ulcer, it became apparent that ulceration did recur even after subtotal gastrectomy. Usually the patients were found to have persisting free hydrochloric acid in the gastric contents and the erroneous conclusion was drawn that an insufficient amount of stomach had been removed. This opinion later was modified in this country, for in 108 cases reported from one eastern hospital in which partial gastrectomy or subtotal gastrectomy was performed for duodenal ulcer, relative achlorhydria occurred in but approximately 56 per cent.[10] Of greater significance, it seems to me, was the fact that in 44 per cent of the cases hydrochloric acid persisted or recurred in gastric secretion, and in nine cases gastrojejunal ulceration developed. In taking the series of 108 cases reported from this eastern hospital as a group, the incidence of gastrojejunal ulcer after partial gastrectomy was found to be 8.3 per cent.[10] With the general recognition of the fact that gastro-enterostomy carried a much lower surgical mortality rate [2] than partial gastrectomy,[3] and of the fact that, in our experience at the Mayo Clinic, as well as in the reports of other surgical clinics, gastrojejunal ulcer appeared in approximately only 3.2 per cent of cases,[2] we could not see the necessity for the routine performance of partial gastrectomy for primary duodenal ulcer, on a comparative basis of formation of gastrojejunal ulceration.

Gastritis.

The next wave of enthusiasm favoring partial gastrectomy for duodenal ulcer had its origin subsequent to the work of Konjetzny, Puhl, and others, who emphasized the high incidence of gastritis associated with duodenal ulcer noted among German surgical patients, and it was thought by these observers that gastritis was the forerunner of the development of the duodenal ulceration. This high incidence of ulcerative hemorrhagic gastritis, stated to be characteristic of from 99 to 100 per cent of German patients operated on for duodenal ulcer,[11,12] led Snell and me,[31] in 1931, to visit various surgical clinics in Germany, Austria, and Hungary. In studying the resected portions of the stomachs of patients operated on for duodenal ulcer in those countries, as well as specimens previously removed by Schmieden at Frankfurt, Snell and I were impressed by the high incidence of gastritis present in the German cases in contrast to the very low incidence of gastritis associated with duodenal ulcer among patients on whom I had operated at the Mayo Clinic. These observations were published in a series of papers in the years 1931 to 1933,[4,20,22,23,24,27] and the accuracy of the observations was confirmed by Sebening, of Schmieden's clinic, who spent several months in study at the Mayo Clinic. The very infrequent occurrence of gastritis among patients operated on at the Mayo Clinic for duodenal ulcer, in comparison with those operated on at the German clinics, is probably explainable on the basis of so-called geomedical variation of types of lesions and by the part played by racial factors in these differences, which has been commented on by von Haberer and by Schittenhelm. The latter, gathering data from various parts of Germany, has emphasized the fact that disease frequently presents different characteristics even in localities where it first appeared. Quoting briefly from Schittenhelm's report: "Apoplexy, atherosclerosis, and thrombosis are more frequent at Basel than at Kiel. Gastric and biliary disorders, likewise, present distinct regional differences—the part played by racial factors in these differences is as yet unknown to science." Further lending support to the geomedical differences in gastritis associated with duodenal ulcer, is the fact that in a paper published by Aschner and Grossman, gastritis was reported as existing in approximately 60 per cent of the portions of stomach resected for duodenal ulcer in contrast with its

presence in less than 12.5 per cent of the series of resected gastric specimens on which I reported from the Mayo Clinic, where in a series of cases partial gastrectomy had been performed for duodenal ulcer.[4,27] The corollary of this would seem to be, therefore, that, since, in our experience, gastritis has been such an infrequent accompaniment of duodenal ulcer, any argument directed toward the value of removing such areas of gastritis in the performance of partial gastrectomy for duodenal ulcer could not be used in favor of such a procedure in cases of the type in which we usually operate.

Partial Gastrectomy for Duodenal Ulcer.

Having discussed and eliminated, I believe, the factor of gastritis as an indication for partial gastrectomy in the cases in which we have operated, and having stressed the low incidence in several series of cases of recurring ulceration after gastro-enterostomy, in contrast with a much higher incidence of recurring ulceration after partial gastrectomy in another series of cases, the important matter to be settled would appear to be just what partial gastrectomy accomplishes in a better fashion than either gastro-enterostomy or pyloroplasty. That question, it seems to me, can be answered rather briefly in the statement that partial gastrectomy accomplishes greater reduction of free hydrochloric acid in the gastric secretion (provided the Polya type or the Hoffmeister-Polya type of anastomosis is made) and in a greater percentage of cases than does gastro-enterostomy or pyloroplasty. Friedell[6] and I have found that relative achlorhydria will occur in approximately 75 per cent of cases in which the Polya type of partial gastrectomy is performed (provided an entero-anastomosis is not made) in contrast with the occurrence of relative achlorhydria in 10 per cent of cases after gastro-enterostomy.[29] Of equal interest is the comparative infrequency, in my experience, with which relative achlorhydria is obtained after gastric resection for duodenal ulcer when the Billroth I type of anastomosis is made; in other words, when the end of the stomach is sutured to the duodenum after resection of half or two-thirds of the stomach. This result is in rather marked contrast with the changes in acidity which follow similar procedures carried out in the treatment of gastric ulcer.

Resistance of Tissue.

Such a discussion of gastric acidity is important, in spite of the fact that gastric acidity plays a secondary part in the formation of either a duodenal or a gastrojejunal ulcer. Resistance of tissue or susceptibility of tissue to inflammation or ulceration from the hydrochloric acid or gastric secretion is that on which successful surgical treatment or duodenal ulcer depends, for, if tissue is resistant to hydrochloric acid, the patient will obtain an excellent result from the recognized types of surgical procedures without recurring ulceration, whereas if the tissue is susceptible to recurring ulceration, and if hydrochloric acid of the gastric secretion continues to be in contact with such susceptible tissue, ulceration may recur. Unfortunately, there is no way at present to measure, *in vivo,* in the individual case, resistance of intestinal tissue to gastric secretion.

What place, then, has partial gastrectomy in the treatment of duodenal ulcer? Theoretically it would appear that it has a place in the treatment of hemorrhagic duodenal ulcer, principally because it removes the bleeding lesion and is able to assure the patient a maximal degree of reduction of gastric acidity. In a recent study by Cleveland[30] of a series of patients operated on for bleeding duodenal ulcer at the Mayo Clinic during the years 1932 to 1936, on whom partial gastrectomy was performed, 94 per cent of the patients obtained satisfactory results and had no further occurrence of ulcer pain or hemorrhage in the period of four to eight years which had elapsed since their operation. Recurring hemorrhages, however, have been reported after gastro-enterostomy in 23 per cent of cases. Yet in many cases of bleeding duodenal ulcer gastro-enterostomy suffices to heal the duodenal lesion. Partial gastrectomy has an important place in the treatment of recurring duodenal ulceration and in gastrojejunal ulceration. The reasons for its usefulness in this group of cases are similar to those for its usefulness in the treatment of bleeding ulcers, namely, that it gives the patient a maximal reduction of gastric acidity. It has an important place among that group of patients who are unable to be selective of diet, working conditions, and habits subsequent to operation, and it will have a place in the treatment of the patient who has duodenal ulcer and whose tissue is abnormally susceptible to recurring ulceration from the irritating effects of hydrochloric acid in gastric secretion.

In 1939,[7,17,26] at the clinic 18 per cent of the patients for whom diagnosis of duodenal ulcer was made were treated surgically. Of this group of 413 patients, 186, about 45 per cent, were subjected to partial gastrectomy. In 1940, approximately 13 per cent of patients seen at the clinic for whom diagnosis of duodenal ulcer was made were operated on, and in 40 per cent of these cases partial gastrectomy was performed.

During the last five or six years the use of local operations at the outlet of the stomach in the treatment of duodenal ulcer has decreased until these procedures seldom are employed (1.4 per cent of cases in which operation was performed for duodenal ulcer in 1940). During the last five-year period at the clinic, gastro-enterostomy has been performed in more than one thousand cases for chronic and subacute duodenal ulcer, with a mortality rate of 2.1 per cent. During this same interval, partial gastrectomy was performed in about 500 cases, also for similar lesions, with a mortality rate of 4.1 per cent. During 1940 the mortality rate in 140 cases in which partial gastrectomy was performed for duodenal ulcer was 4.3 per cent.

Although this mortality for gastric resection is not high, nevertheless it is definitely higher than that for gastro-enterostomy, and this fact should always be kept in mind in selecting the operation for a given patient.

In order to see whether this increase in risk was justified in the results which followed, Dr. E. B. Lewis, Dr. Robert G. Lemon and I [34] carried out a study of 212 consecutive cases in which primary partial gastrectomy of the Polya type had been performed for duodenal ulcer. Although this was a consecutive series of cases in which partial gastrectomy had been done, it is not to be assumed that it was a consecutive series in which the patients were operated on for duodenal ulcer, for in many cases the large size or the character of the ulcer or the condition of the patient would not permit partial gastrectomy without excessive risk; in such cases gastro-enterostomy usually had been performed.

Anastomotic jejunal ulceration occurred after partial gastrectomy in 2.5 per cent of the cases studied. Thus, in a total of 97.5 per cent recurrence of ulceration after partial gastrectomy did not occur. After the operation, 83.5 per cent of patients were well without undue restriction of diet or activity. Because of vagotonic symptoms such as temporary faintness and sweating after meals, 14 per cent required restriction of diet or activity.

In those cases in which analyses of gastric contents were obtained after operation, anacidity was present in two-thirds to four-fifths of those in which recurrent ulceration did not occur, and only rarely was a normal or greater than normal value for free acid obtained. When a jejunal ulcer was demonstrated, almost invariably greater than normal amounts of free acid were present.

In presenting the results of partial gastrectomy for bleeding lesions of the stomach and duodenum at the meeting of the American Surgical Association last week, Cleveland and I [30] called attention to two facts which I think should be kept constantly in mind by those surgeons contemplating partial gastrectomy for duodenal ulcer, namely, that failure to remove the pylorus and the performance of an entero-anastomosis between the loops of jejunum were responsible for practically the only instances of recurring ulceration which occurred. Experimental and clinical evidence points to the fact that when the pylorus is allowed to remain, the marked reduction of gastric acidity which occurs when the pylorus is removed in the course of partial gastrectomy does not occur. This evidence indicates that in the pyloric region, factors stimulating the production of gastric acidity are present.

In twenty cases in which Ogilvie of London performed partial gastrectomy and did not remove the pylorus, recurrence of ulceration took place in five, whereas in one hundred cases in which pylorectomy was done as a part of the partial gastrectomy recurrence did not take place. The effect of entero-anastomosis is to prevent the dilution of gastric secretion and the reduction of gastric acidity by the reflux of alkaline duodenal contents into the gastric pouch. Although it must not be assumed that in every case in which entero-anastomosis has been performed ulceration is likely to recur, nevertheless the fact remains that the cases of bleeding gastric and duodenal ulcer in which there was failure to obtain excellent results after partial gastrectomy were, for the most part, those in which the pylorus had not been removed or an entero-anastomosis had been made or a Billroth I type of operation performed. A corollary of this, it seems to me, is the fact that in a given case in which it is desired to perform partial gastrectomy for duodenal ulcer there must be sufficient normal uninvolved duodenum distal to the duodenal ulcer so that the ulcer can be removed and the duodenum accurately closed, or if the ulcer is too large and is situated too low for removal, there should be sufficient normal duodenum between it and the pylorus so that this portion of the duodenum can be accurately closed and leakage obviated, for in most cases leakage from the duodenal stump is the cause of the patient's failure to recover from the operation.

SUMMARY

The frequency of the ulcer type of syndrome in cases of malignant lesions of the stomach and the temporarily effective response of patients to a medical regimen is noteworthy. Of equal importance is the fact that such a syndrome was the first indication of malignant gastric disease in approximately a third of the presented cases in which operation was performed.

The accuracy of roentgenologic diagnosis in cases of lesions of the stomach and duodenum is well known, but it is less well known that there are definite groups of cases in which radiologic examination reveals lesions which appear to be gastric ulcers, but which on pathologic examination prove to be carcinomas, sometimes of high degree of malignancy. This fact should be repeatedly emphasized. In 10 per cent of a large series of cases in which gastric resection was performed from 1907 to 1938, inclusive, for malignant lesions, preoperative diagnosis of gastric ulcer had been made roentgenologically. In the year 1939, diagnosis of gastric ulcer was made in 7 per cent of the cases in which gastric resection for cancer was performed. In 20 per cent of the cases in which the lesion was reported on roentgenologic examination to be inoperable or of doubtful operability, it was found on surgical exploration to be operable.

The five-year survival rate for those patients who underwent resection is 29 per cent, and when this rate is adjusted for the normal death rate it is 32 per cent. The ten-year survival rate is 20 per cent, and when it is adjusted for the normal death rate, it is 25 per cent. The fifteen-year survival rate is 15.2 per cent; twenty year, 10.5 per cent; and the twenty-five year, 6.3 per cent.

Although many small gastric ulcers will heal under medical regimen properly carried out, the possibility of the lesion being an ulcerating carcinoma which, in roentgenograms, simulates a gastric ulcer must always be remembered, and since the likelihood of large chronic gastric ulcers healing medically is very small, surgical treatment should be carried out in such cases. The operative mortality, under proper circumstances, in these cases should not exceed 4 or 5 per cent.

The treatment of duodenal ulcer has undergone considerable revision in the United States in the

last ten years. As a result of a decreasing percentage of patients who have duodenal ulcer for whom surgical procedures are advised, more radical procedures have been carried out; hence the increasing percentage of cases in which partial gastrectomy, rather than pyloroplasty or gastroenterostomy, has been performed. There is a definite place for gastro-enterostomy in the treatment of duodenal ulcer, and experience has shown that partial gastrectomy is the preferable surgical procedure in certain groups of cases, particularly those of hemorrhagic ulcer and those of ulcer diathesis, as well as in those cases in which the patients cannot be expected to follow a regulated regimen of diet and habits subsequent to operation.

The Mayo Clinic.

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THE PRACTITIONER AND PROBLEMS OF DIABETES*

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IN the capacity of an internist rather than as a specialist, I have elected to discuss certain general problems which confront the practitioner in relation to problems of diabetes. This afternoon I should like, at the outset, to make a plea for the viewpoint that diabetes can and should be treated more generally by the practitioner. The high incidence of diabetes among the population in itself justifies this point of view. Furthermore, treatment has been simplified to an extent whereby the vast majority of cases today afford but few problems in which special knowledge is necessary. This idea constitutes merely part of a general thesis, namely, that the place of the specialist in the various branches of internal medicine, including diseases of the circulatory system, the gastro-intestinal tract, the respiratory system and the kidneys should be consultatory and reserved for the exceptional case.

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With the current tendency to set up numerous boards of specialization in the various branches of medicine, the internist will have more and more to foster his art and extend his scientific knowledge in order to maintain the place of the general practitioner, and to avoid the further subdivision of medical practice, which might ultimately reduce it to an absurdity.

There are, I believe, two outstanding reasons why the care of the patient with diabetes mellitus is avoided by many practitioners. The first is that it is still a matter of common belief that the knowledge necessary and the facilities essential for the intelligent management of the diabetic patient present extraordinary difficulties. The other reason is found in the tedium of detail inherent in diabetic therapy—about which there is nothing to be done.

HISTORICAL CONSIDERATIONS

I feel that a brief historical consideration of the development of diabetic therapy will help to trace the origin of the aura of complexity conventionally associated with it. It will also serve to demonstrate why diabetic therapy has, in recent years, become a relatively easy matter.

At the turn of the last century, the laborious chemical methods which had been employed in the study of normal metabolism began to be applied to the study of diabetes, particularly following Minkowski's observation that diabetes could be produced in animals by extirpation of the pancreas.

A significant era in the history of diabetes had its inception between the years of 1910 and 1915. This was based upon F. M. Allen's important observation that removal of 9/10ths of the dog's pancreas produced diabetes, and that fasting the dog made the animal sugar-free. As a result of these observations Doctor Allen developed his treatment, the basis of which was undernutrition. Instead of simplifying dietetic management, however, the Allen era further complicated it because it became the sine quo non of good diabetic therapy that all patients should remain sugar-free at any cost. To attain this aim it was often necessary to prepare those culinary atrocities known as "diabetic fillers" consisting of thrice-cooked vegetables and washed bran. Practical dietetics was further complicated by the general lack of well-trained dietitians and also the lack of simplified food scales as they exist today. To the complexity of dietary treatment at the time was added the bugbear of establishing carbohydrate tolerances. This often went on for weeks, requiring day-by-day increases of a few grams of protein and fat and, finally, of carbohydrate, and it proved a trying procedure both to physician and patient. The establishment of the tolerance had to be redetermined from time to time with changes in the severity of the disease within a single patient. These studies were always accompanied by the daily quantitation of the urinary sugar—even to the second decimal point in the most meticulous clinics. These attempts at regulation were often interspersed with periods of fasting of 10 to 14 days' duration, which were agonizing to witness and still more agonizing to the patient. It is quite obvious that all of this treatment necessitated the hospitalization of the patient, and that the laboratories and dietetic staffs of but few institutions were equipped to deal with these complexities.

DIABETES—DURING THE LAST TWO DECADES

In the past twenty years, diabetes has not changed. Its management continues to be a matter of detail—perhaps rather more than less. Furthermore, the life-span of diabetics has been materially increased, so that their care is complicated to a great extent by the degenerative diseases of old age. Each diabetic must be treated as an individual, as in the past, and the success of therapy continues to depend primarily upon the coöperation and diabetic education of both patient and physician, and upon meticulous attention to details of diet and urine examination. Nevertheless, with but rare exception, the treatment of diabetes has become greatly facilitated. Contributing to this simplification are a number of factors. In the past two decades standard insulin and protamin zinc insulin have been made available, and patients no longer need die of malnutrition. Thanks to the vast experiences gained in a number of diabetic clinics, the process of calculation and preparation of diets has been simplified to a degree comparable with that which has taken place in the feeding of infants in recent years. The laborious task of establishing carbohydrate tolerance, as it existed in the preinsulin days, is now rarely necessary. Also, today the trained diabetic with rigid restrictions of diet is no longer required to weigh his food, once he has learned approximate values. Blood sugar and bicarbonate determinations are today available to physicians in virtually all localities—twenty years ago only the larger hospitals were equipped for these guides to therapy. Methods of testing urine for sugar have been, as you know, incredibly simplified, and only in rare instances is it necessary to quantitate the grams of glucose excreted. Furthermore, a number of excellent manuals for diabetic patients have been lucidly written, presenting the elementary physiological concepts and the details essential to relieve the physician of a large part of patient training.

TREATMENT

It is quite impossible and equally unexpected that I attempt to discuss extensively or in great detail the present-day management of diabetes. I should like, however, to dwell upon a few points which, in my experience, have served as aids in the further simplification of therapy, once the diagnosis is established.

The chief aim in treatment, as I see it today, is to maintain patients in a state of health, normal weight, and happiness, and to keep them approximately sugar-free. In the days before the advent of insulin it was all too frequently impossible to maintain weight, health and happiness. However, we took a measure of solace in having many patients die of inanition, but sugar-free.

In order to achieve the therapeutic aims set forth, different types of régimes are obviously required, but all patients can be placed in one of three cate-

gories. In the first, insulin treatment is unnecessary; in the second, insulin therapy is either optional or advisable; and in the third, insulin therapy is obligatory. Thus it is apparent that the first consideration in diabetic therapy today is to determine whether or not an individual will require insulin. I do not refer here to those complications such as acidosis or severe infection in which insulin is uniformly indicated, but rather to the maintenance requirements of the patient.

WHEN INSULIN IS NOT REQUIRED

The first category of diabetics mentioned, that is, patients who require no insulin and in whom insulin therapy is even undesirable, comprises happily approximately 25 per cent of all diabetics. Patients in this group are usually easily recognized. This category is made up almost exclusively of patients whose disease either begins or is first recognized after the age of 50. Furthermore, at least 85 per cent of these patients are definitely overweight or truly obese. These same patients more frequently than not are discovered to have diabetes in the course of a routine examination, or because of complications such as pruritus, furunculosis, peripheral neuritis, lack of energy after a bountiful repast, or because of the commoner arteriosclerotic manifestations.

The management of this group of patients is usually, but not invariably extraordinarily easy. This is most dramatically emphasized by the striking decrease in diabetes in Germany during and just after the conclusion of World War number one, a result dependent solely upon food deprivation. Obesity under these conditions of privation tended to vanish and with it diabetes. Fortunately, it does not require war to control diabetes in our first category, but rather the control of obesity. The large number of the patients to whom I have reference are diabetic if they continue the caloric intake necessary to sustain obesity. On the other hand, their food tolerance is sufficiently great to permit them to remain sugar-free with the calories required to hold their weight at a more normal level. The following case record serves as an example and can be duplicated many times in the records of all physicians who treat diabetes. A business executive of 53 who had been in good health but for his weight, which had gradually risen from 180 to 225 pounds, sought medical attention only for a small furuncle on his nose. Except for this local condition, physical examination was normal. His urine contained a 2 to 3 plus glucose reaction, and his fasting blood sugar was 200 milligrams per cent. Desugarization was accomplished by the withdrawal of free sugar from his diet, and a reduction in the intake of starches and butter sufficient to initiate weight loss. When this patient maintains his diet at a level so that his weight remains below 185 pounds, he is no longer a diabetic. That is, he is sugar-free and his fasting blood sugar is usually below 150 milligrams per cent. If he increases his caloric intake and gains weight, his blood sugar begins to rise. This patient, after twelve years, has shown no progress in his disease. He avoids sugar, and is judicious in guarding against weight gain by moderate restriction of starchy foods.

There is no need to bother this type of patient with education in the techniques either of weighing food or estimating carbohydrate intake. If he understands the principles of weight reduction, if he keeps, for a time, a diary of his daily menus which fulfill his dietary requirements and limitations, and if he follows his weight, his problems are largely solved. Naturally, this mild type of diabetic must share in the general education of all patients with diabetes. These patients, as all others, must learn to test their urine for sugar. They must be made aware of the dangers of infection, and must learn that medical advice must be sought immediately when infections appear. They must learn to care for their feet, etc. Once regulated, the patients in category one need test their urine perhaps only at weekly intervals, whereas blood-sugar determinations are not indicated more than once or twice a year, unless symptoms or complications appear or unless weight is gained.

WHEN INSULIN THERAPY IS OPTIONAL OR ADVISABLE

The second category of diabetics to whom I have made reference includes those patients in whom the use of insulin is either optional or advisable. Included in this group are practically all of the diabetics over 50 years of age who do not fall into category one and a considerable number of diabetics in whom the disease makes its appearance in the decade of 40 to 50. But few diabetics under the age of 40 can properly be added to this class. Obesity is perhaps a less prominent feature in this group of patients than in the first category and, indeed, it is not infrequently absent. As is also true of the first category, relatively few of these patients begin their disease with the abrupt onset of polydypsia, polyphagia and polyuria.

The patients of this group are characterized by the fact that they can be kept sugar-free, and in normal weight, by dietary means alone. To accomplish this, however, they must restrict their carbohydrate rigidly and raise the intake of fat to levels which are often unpalatable and not infrequently distressing, e. g., 150 grams. It seems to me that, except in rare instances, it is far better to plan for these patients a diet embracing a much more normal distribution of foodstuffs, e. g., one containing, let us say, 200 rather than 100 grams of carbohydrate with a corresponding decrease in fat. To accomplish this end, which results in most instances in far greater contentment and, consequently, better coöperation, a single morning dose of insulin is usually adequate.

When the patients of this category can be recognized, time and expense are saved by starting them at once on the dietary régime which appears indicated for their maintenance. The process of desugarization can best be accomplished simultaneously by the use of larger doses of insulin than will be ultimately required. There is no need to employ

one of the classical low calorie diets, e. g., 60-60-60, for the purpose of desugarization.

In a few instances patients elect the more rigid restrictions of diet necessary to remain sugar-free, without the use of insulin. In these cases the tedious time-worn procedure of desugarization on a low dietary régime must be employed. Fat and protein may then be added as desired, as the chief sources of energy and finally carbohydrate to the point of glycosuria. As I have stated, this type of régime is rarely to be advocated, but it may be employed.

WHEN INSULIN IS OBLIGATORY

The third and last category of diabetics includes the younger adult and all children. In this group the onset of the disease, with its classical symptoms, is indeed common. This is the category in which the use of insulin is obligatory. It is obligatory, in my opinion, despite the fact that most of the patients may have, for some time after initial desugarization, a food tolerance entirely adequate to maintain their health and body weight and to remain sugar-free without insulin. Experience of the preinsulin days taught, however, that the tolerance of this younger group gradually diminishes to a point where energy requirements cannot be met without glycosuria. This being the case it seems best to start the treatment of patients of category three with what appears to be a maintenance diet and with insulin therapy.

In this third category, as in the second group mentioned, a large number of patients can today be controlled with a single dose of insulin. It is, however, in this third category that we also encounter most of the "difficult diabetics." Happily they constitute but a small percentage of all diabetics, but they are difficult. It is my experience—and I find some comfort in it—that the diabetics who prove difficult for the practitioner also prove difficult for the specialist. It is the privilege and the duty of the specialist to treat them, but before delivering them to the specialist, the family physician should be certain that the difficulty is not just an apparent one, and dependent upon underlying hyperthyroidism or infection. The difficult diabetics, I hardly need add, are the individuals who appear to require large amounts of insulin given in a number of divided doses during the day and night, and who appear to oscillate between hypoglycemic shock at one moment and heavy glycosuria the next.

ON DIET MANAGEMENT AND INSULIN ADMINISTRATION

Having attempted to indicate certain simplifications in the classification of patients with diabetes, and having outlined the approaches to treatment in these groups, I should like to discuss briefly a few practical considerations of diet management and insulin administration which often prove to be the determining factors in the successful management of patients requiring insulin treatment.

I do not desire to enter the old controversy over the relative merits of high and low carbohydrate diets. I would rather make a plea for "reasonableness." If a diabetic is overweight, it is generally wisest to institute a diet which will bring about gradual reduction—not necessarily to the ideal weight, but at least in that direction. If a patient is definitely undernourished, his diet should be planned to correct that error of nutrition. If weight is approximately normal, I prefer to interfere as little as possible with a patient's food habits and desires except, of course, for the prohibition of free sugar, and adjusting insulin requirements in accordance with his needs.

As has been stated most patients in our first category are overweight and do not require insulin—this group does well with the type of low calorie diet used even in the absence of diabetes. On the other hand, patients in categories 2 and 3 who require insulin should receive a large enough amount of carbohydrate to avoid what is properly termed "starvation diabetes." All too frequently a diet is prescribed with little carbohydrate, perhaps 100 grams or less, with the vain hope that this may simplify the régime, and that the insulin requirement will be small. This is a fallacy of thought which should not be perpetuated, because among patients treated in this matter we often find alternations of shock and glycosuria which need not exist. Indeed, a diet containing 200 grams of carbohydrate in the same individual will usually be tolerated with only a small increase in insulin requirements, and with fewer oscillations between hypoglycemia and glycosuria.

IMPORTANCE OF MINUTE DETAIL

I regret to say that, in my opinion, one of the most important of all factors determining the success of diabetic therapy among patients using insulin is a matter of minute detail. I have in mind the question of distribution of the daily carbohydrate ration. On a given dosage of standard insulin a patient frequently remains sugar-free, and free from shock when the carbohydrate given is divided as 2/5, 1/5 and 2/5 between the three meals, whereas, when divided into 1/3, 1/3 and 1/3, the patient will shock before lunch and spill sugar before supper. In patients receiving protamin zinc insulin, the detail of food distribution is of even greater importance than in those using standard insulin. As you know, many of these patients require supplements of carbohydrate between meals—usually at bed-time, and often between other repasts. Whereas most of these patients do best with a carbohydrate distribution of 1/5, 2/5 and 2/5—part of the supper carbohydrate being saved for the evening—each individual is a law unto himself. This means that "tinkering" with food distribution is a legitimate part of the physician's work—whether he be a general practitioner or a specialist. There is nothing complicated about saving a slice of bread from lunch for tea, and one from supper for bed-time; but arranging this is, from the physician's standpoint, an essential but undeniable chore.

When the decision is reached that removes a diabetic from the first category and when it is decided that insulin therapy should be instituted, the choice

of the *type of insulin* to be used becomes a problem. The enthusiasm which accompanied the introduction of protamin zinc insulin has abated. It is no longer looked upon as a panacea, despite the fact that its prolonged action (24 hours or even more at times) flattens out the upswings in sugar curves. It is now recognized that its use must be restricted, and that often it must be supplemented with standard insulin to prove successful. On the other hand, the prolonged and severe shocks which result from the abuse of protamin zinc insulin no longer justify the condemnation of this most valuable adjunct to diabetic treatment. The greatest value of protamin zinc insulin lies in the fact that it has made possible a reduction in the number of daily injections in many patients of our third category, i. e., patients in whom insulin therapy is obligatory. For example, one of our first insulin patients at the Presbyterian Hospital, who has been under the care of Dr. Rawle Geyelin in New York, formerly required three or four injections of standard insulin to keep him approximately sugar-free on his liberal diet including 400 grams of carbohydrate (125 of protein and the same of fat). Now he takes an injection of 82 units of protamin zinc insulin and 24 of standard insulin one-half hour before breakfast—no other injections are necessary. He is sugar-free and does not suffer shock. Incidentally, this man takes part of his carbohydrate between breakfast and lunch, between lunch and supper and when he goes to bed, finding, as is true of most patients, this a minor inconvenience in comparison with the alternative nuisance of multiple injections of insulin. If protamin zinc insulin is to be used, it is my feeling that it should be administered only in the morning. Multiple doses, with their prolonged action, lead in most cases to dangerous and unpredictable shocks. I can see no virtue in giving the daily dose before supper: it is a most inconvenient hour for most people and has little practical value.

Among the patients of category three, those in whom insulin therapy is mandatory, protamin zinc insulin should be tried at the outset. It is in this group, however, that the use of standard insulin is an essential supplement to prevent heavy glycosuria between breakfast and lunch. When multiple doses of insulin become inescapable, as is occasionally true for the successful management of patients in this group, I can see no virtue in continuing the use of protamin zinc insulin, and feel that multiple doses of standard insulin simplify regulation.

There is one detail of insulin therapy which seems of sufficient importance to warrant emphasis. This is the fact that attempts to adjust the dosage rapidly, in order to save time, usually result in the appearance of glycosuria or hypoglycemia, and actually delay the final regulation of the patient. In other words, haste makes waste. It almost invariably proves a mistake to alter individual doses more than 5 units a day in the course of regulating a patient. Furthermore, to make radical increases or decreases in insulin and diet simultaneously results in confusion.

I have attempted to emphasize that diabetes mellitus is a disease to be treated by the practitioner, and that its treatment has been greatly simplified in recent years. I have also made reference to certain generalizations and a few details which may still further simplify the problems of therapy.

COMMENT

Before closing I should like to make brief reference to recent physiological studies which throw light on the mechanism of diabetes, and which may conceivably prove of great importance in its prevention.

For many years it had been suspected that at least certain cases of diabetes mellitus did not result from primary intrinsic disease of the pancreas. But it remained for Houssay to prove first the antagonism between the anterior hypophysis and the insulin function of the pancreas. As you know, he demonstrated that hypophysectomy relieved the diabetes of pancreatectomized dogs, and that the administration of crude anterior pituitary extracts again called forth glycosuria and hyperglycemia in these animals. Long and Lukens then demonstrated a similar relationship between the adrenal cortex and the pancreas. Thus, they showed that adrenalectomy relieved hyperglycemia, glycosuria and ketonuria in depancreatectomized cats.

Young in England, in 1938, made another contribution of extraordinary importance. He demonstrated that a course of daily injections of anterior pituitary substance, administered over the course of a month, induced permanent diabetes in normal dogs. That is to say, after cessation of the injections, hyperglycemia and glycosuria persisted indefinitely. Since that time, Best in Toronto has shown that these anterior pituitary injections cause fibrosis of the majority of islands of Langerhans, the lesions being indistinguishable from those commonly present in the human disease. Of great significance is the fact that Best was able to show that, if insulin was administered to his dogs, or if carbohydrate intake was restricted while they were receiving injections of the diabetogenic anterior pituitary hormone, the establishment of diabetes could be prevented. Thus it was shown that the prevention of diabetes could be brought about by an excess of insulin or a decrease in carbohydrate.

More recently Lukens and Dohan have made the observation that it is impossible to induce diabetes in intact cats with Young's technique. However, removal of one-half of the pancreas makes them vulnerable to anterior pituitary injections, and permanent diabetes can be established. The most striking feature of this work is that diabetes can be cured in these animals, so that continued insulin treatment is unnecessary, provided one of three methods of treatment is initiated during the first five months after permanent diabetes is established. For example, the diabetes is curable if (1) insulin is given in doses large enough to prevent hyperglycemia, or (2) if hyperglycemia is prevented for a week by administering phlorizin, or (3) if the normal blood sugar is maintained by giving a low carbohydrate diet. If, on the other hand, the cats are inadequately treated during this period by one of these means, the diabetes can be controlled, but

it is no longer curable. The apparent reason for the fact that diabetes can be cured in these cats in the first five months is that the islet tissue during this time shows hydropic degeneration only. After five months, when the disease cannot be cured, the islands have become fibrosed. In the dog, it has not been possible to cure the diabetes, once it is established as the islet tissue in this species fibroses more rapidly than in the cat. Whether human beings are more like the dog or the cat has not been determined; but in respect to diabetes I suspect that they are more like the dog.

It is far too early to attempt to draw any conclusions concerning the application of these studies to the problem of prevention of human diabetes. Nevertheless, this work is highly suggestive, and shows that preventing hyperglycemia, by giving insulin during the time of administration of excessive amounts of anterior pituitary substance, prevents the development of diabetes, and that preventing hyperglycemia by giving insulin to cats with early diabetes cures them.

IN CONCLUSION

We know that the majority of human beings developing diabetes are obese, and we know that when overnutrition is abolished in a community the incidence of diabetes is decreased. It seems to me that these recent studies suggest again a possible relationship between exhaustion of insulin supply and diabetes. I therefore should like to make a final plea that the practitioner of internal medicine push his campaign against obesity in his community. If he is successful in this endeavor, it may well be that he will be beset with fewer diabetic chores, however much treatment may have become simplified.

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INTESTINAL BLEEDING IN INFANTS AND CHILDREN*

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BLEEDING from the intestinal tract in infants and young children occurs not infrequently, and may be of such severity as to require emergency treatment. It may be due to a variety of pathological conditions, and have its origin anywhere from the esophagus to the anal canal. My discussion will be confined to the more common conditions which are of mutual interest to pediatricians, surgeons, and roentgenologists.

All too frequently the physician's attention is directed by the parents to a stool which may appear to contain blood, but actually does not. Certain of the modern prepared fruits and vegetables, particularly beets, and medications containing iron, may produce an apparently bloody stool. This error at times may be made also by the physician, and the first requirement on examination is to be sure that the material under suspicion is blood.

A good deal has been said about the gross appearance of blood in the stool as an indication of the source of the bleeding, it being implied that fresh, bright-red or clotted blood has its origin in the anus, rectum, or lower colon; that the typical, black, tarry, altered blood originates high in the small intestine, and that the presence of both types implies bleeding from a point low in the small bowel or high in the large bowel. In many instances this implication is substantiated when the bleeding point is located, but such a general statement must not be accepted as reliable. Bleeding from a point high in the small bowel may be of such size that fresh, bright-red or at times clotted blood will be passed by rectum.

SINGLE POLYP

An adenomatous polyp of the rectum is a very common cause of bleeding from the bowel in young children. The vast majority of polyps occur singly from the posterior wall of the rectum or in the lower sigmoid. They are bright red in appearance, fairly vascular with a definite glandular structure, and are usually attached to the bowel wall by a nonindurated pedicle and may be present at birth (Fig. 1). Ulceration and erosion of the mucous membrane result in bleeding. Hemorrhage is seldom massive, usually occurs with or after defecation and the blood is fresh, bright red and frequently clotted. The usual history is that of recurring periods of bleeding, practically daily for several days, followed by a fairly long interval of normalcy. The polyp may prolapse through the anus on defecation or may grow to such a size as to produce partial obstruction. At times the patient may exhibit urgency and a frequent desire to defecate with unsatisfactory and incomplete, small stools.

A polyp of the rectum should be suspected when there is fresh bright-red blood passed in small amounts. Frequently the polyp can be felt on digital examination, and most are visible through a proctoscope. The dangers of repeated, though small hemorrhages, the possibility of partial obstruction due to size, and the later development of malignancy make surgical removal of the polyp necessary. This can be done by ligation and excision or by electrocoagulation of the pedicle.

A single adenomatous polyp may occur high in the sigmoid or colon. These cannot be visualized or palpated, but are demonstrated roentgenologically by a contrast enema. Air insufflation after partial defecation aids greatly in their demonstration. Tumors in this portion of the bowel require laparotomy and removal of the polyp by transection of the bowel. This procedure is seldom difficult.

MULTIPLE POLYPOSIS

Multiple polyps in the colon are not rarities in children, and should be suspected even when a typical single polyp has been identified in the rectum. "Multiple polyposis," "polypoidosis" or "adenomatosis" are terms commonly used to indicate a condition of numerous sessile or peduncu-

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Fig. 1.—Single polyp of the rectum (prolapsed) in an infant two days old.

Fig. 2.—Specimen of multiple polyposis following colectomy in a child, age 6.

lated polyps distributed throughout the large bowel. These growths vary in size, consistency and number, depending upon the stage of development. Ordinarily they vary from a few millimeters to several centimeters in diameter. They may be confined to the sigmoid or lower colon, or involve the entire colon from the cecum to the anus. Structurally, the growths are true adenomata lined with columnar epithelium of goblet-cell type, and have a definite tendency to change from benign to malignant. Some authors have estimated that at least 60 per cent undergo carcinomatous change (Fig. 2). The symptoms depend upon the location and segment of the bowel involved and the extent of development of the polyps. Usually the patient complains of colicky abdominal pains, frequent, soft stools or diarrhea, and the presence of mucus and blood in the evacuations. In these instances, also, the blood is usually fresh or mildly altered and appears on defecation. If the process involves the rectum, these multiple small tumors will be noted on digital examination, and on proctoscopic examination a series of sessile and pedunculated, glistening, reddish polypi of varying size will be seen scattered diffusely over the rectal wall. Roentgenological study, with a double contrast enema, should demonstrate conclusively the presence and extent of the disease. Intestinal obstruction, severe hemorrhage, infection, and malignant degeneration may be expected in long-standing cases.

Fig. 3.—Roentgenogram demonstrating intussusception.

Multiple polyposis demands radical surgical therapy even in young children. The tendency to continued hemorrhage and the probability of malignant degeneration, necessitate removal of the portion of the bowel involved in the process. This usually means complete colectomy. If the rectum and lower sigmoid are not involved, or contain only one or two polyps which are accessible through a sigmoidoscope, the operation of choice is a two-stage procedure in which the terminal ileum is sectioned and anastomosed to the lower-most portion of the sigmoid or the upper rectum, followed some three or four weeks later by excision of the colon. Such patients should have frequent examinations of the remaining large bowel, and if polyps develop they may be removed by fulguration. However, the necessity for removal of the remaining large bowel in later years must be recognized. If the rectum is involved to such an extent that it seems unsafe to leave it, then the entire large bowel, including the rectum, must be removed, and a permanent ileostomy established. Satisfactory results of such surgical treatment of multiple poly-

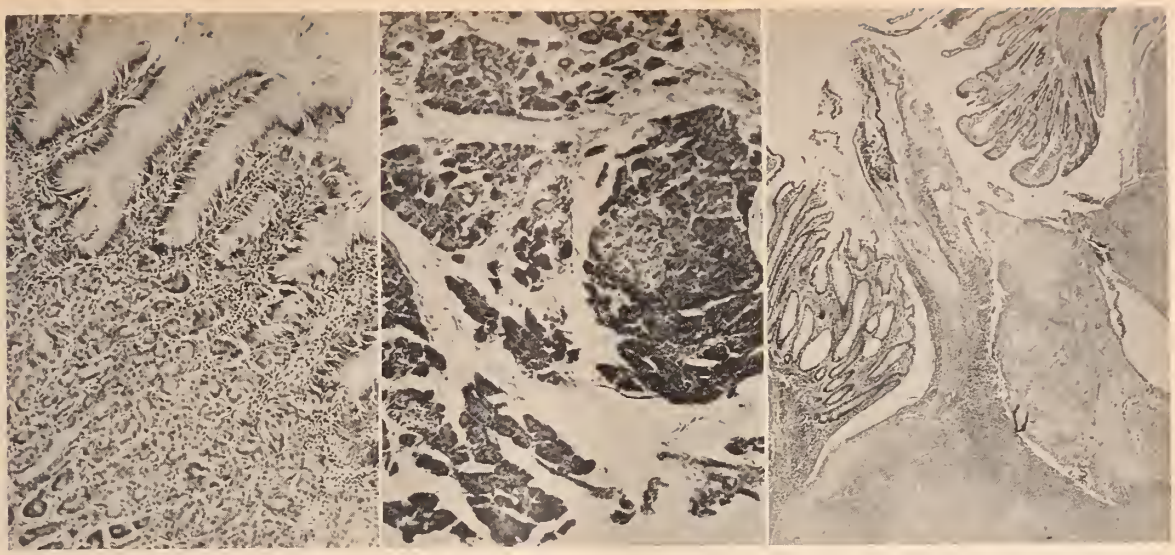

Fig. 4.—Meckel's diverticulum, child, age twenty-two months. Note gastric mucosa, pancreatic tissue and ulcer in jejunum.

posis are being reported with increasing frequency throughout the United States.

INTUSSUSCEPTION

Intussusception, with its resultant acute obstruction of the intestine, is predominantly a disease of the first two years of life. Intussusception is the invagination of one portion of the bowel into another. In about 90 per cent of cases there is a telescoping of the ileum into the cecum, or of the ileum and cecum into the ascending colon, but at times intussusception occurs elsewhere in the small bowel. The presence of a tumor, ulceration or cicatricial stenosis, or other anatomical defect in the bowel, and an abnormally mobile bowel due to a long mesentery, are factors which predispose to the development of intussusception. Obstruction results from the compression of the invaginated bowel and its mesentery. This section of the intestine necessarily becomes violently congested and finally may become necrotic. This vascular congestion is responsible for the presence of an intimate mixture of mucus and blood, which is nearly always found in the rectum although the hemorrhage is never copious. The usual history is that of severe abdominal pain of sudden onset, nausea and vomiting, which may be followed by a single bowel movement. Shortly thereafter a mixture of blood and mucus appears in the rectum. In addition to the usual signs of intestinal obstruction, a sausage-like tumor may be felt somewhere in the abdomen, and of great significance is the finding of an empty right lower quadrant on abdominal examination. The silent expulsion of bright-red bloody mucus from the rectum, particularly just after digital examination, is also highly suggestive of intussusception.

The condition of "chronic intussusception" sometimes exists. By this term is meant an intussusception which throughout most, and usually all of its course, is not accompanied by the signs of acute intestinal obstruction. These patients are apt to have bloody mucus in the stool or an evacuation followed by an expulsion of bloody mucus, and the clinical signs of partial intestinal obstruction.

The diagnosis of intussusception usually can be made from the history and the physical findings, but if doubt exists a picture typical of intussusception may be demonstrated roentgenologically by contrast enema. The enema solution runs freely through the bowel until it meets the intussuscepted segment which stops its advance (Fig. 3). This point of obstruction gives the appearance of a rounded mass projecting from above downward into a slightly dilated segment of bowel.

The relief of intussusception depends upon early diagnosis and prompt operation. The mass is exposed and the invagination reduced by taxis. In the late stages, edema and necrosis may prevent reduction or the bowel may be found gangrenous. This, of course, requires intestinal resection and anastomosis, which are always hazardous in infants.

MECKEL'S DIVERTICULUM

Ulceration, associated with Meckel's diverticulum, is a not infrequent cause of intestinal hemorrhage in infants and young children. This structure is a remnant of the omphalomesenteric (vitelline) duct and is found 15 to 30 inches proximal to the ileocecal valve. It occurs in approximately 1.5 per cent of all individuals. The vast majority of such diverticula produce no symptoms. In approximately 15 per cent of them, heterotopic tissues, usually gastric mucosa, pancreatic tissue or both, are found (Fig. 4). In such instances the physiological secretions from these latter tissues may produce ulcerations of the mucous membrane which have the typical appearance of duodenal peptic ulcers. The ulcer is situated at the mouth of the diverticulum or just distal to it in the wall of the ileum. Erosion of a blood vessel results in a massive hemorrhage. Bleeding from such an ulcer results in the passage of copious blood-clots, which are bright red at times and at others darker in color. The patient exhibits the signs suggestive of

Fig. 5.—Specimen showing duodenal ulcer with blood clot in an infant, age seven months.

shock, with sudden pallor, marked rise in pulse rate, drop in blood pressure, and the rapid development of secondary anemia. The bleeding commonly ceases spontaneously, but usually recurs.

The diagnosis of a Meckel's diverticulum with ulcer cannot be made with certainty except by exploratory laparotomy. A history suggesting peptic ulcer is rarely obtained, roentgenological examination seldom demonstrates the diverticulum or the ulcer, and a mass in the abdomen is not often palpated. Any massive hemorrhage from the intestinal tract of a young child in which large amounts of blood are passed per rectum, particularly when it is sometimes bright red in color and sometimes is darker, is so suggestive of Meckel's diverticulum with ulceration as to warrant operation. The treatment is surgical and usually requires resection of a segment of the intestine, including the diverticulum and ulcer, although small lesions may be excised locally without intestinal resection.

PEPTIC ULCER

Although peptic ulcer is not a common disease in childhood, it occurs with sufficient frequency that everyone should realize its possibility and be on the lookout for it. Very few such ulcers are of the chronic type in children. Most of them are duodenal in location and acute and erosive in character (Fig. 5). The syndrome of epigastric pain and tenderness coming on after meals, relieved by food and alkalis, with periods of remission and exacerbation so commonly found in adults, is usually missing in children suffering from ulcer. Nausea and vomiting are common complaints, however. Not infrequently the ulcer accompanies or follows some severe systemic disease. Hemorrhage may occur from any duodenal ulcer if a blood vessel is eroded. In such instances the blood is nearly always altered by the time it is passed, resulting in a typical black, tarry stool. The hemorrhage may be of such size, however, and its passage through the intestinal tract so rapid, as to result in the passage of some bright-red blood as well as the black, tar-like altered blood. The diagnosis should be confirmed without unusual difficulty by roentgenological examination with a barium meal. Such hemorrhages nearly always stop spontaneously, and are best treated conservatively by medical means. The usual indications for surgery, that is perforation, obstruction due to cicatricial contraction or repeated or excessive hemorrhage, are seldom found in children suffering from duodenal ulcer.

There are numerous other common causes of bleeding, such as the blood dyscrasias, hemorrhagic disease of the newborn, Henoch's purpura, fissure in ano, prolapse of rectal mucous membrane, dysentery, and ulcerative colitis. These should be diagnosed without too much difficulty and are seldom emergency conditions.

Each one of the conditions that has been discussed is a common cause of bleeding from the intestines in infants and children requiring emergency care. They should be considered as possibilities in every instance of intestinal hemorrhage. In each the indications for treatment are nearly always definite and specific. When the diagnosis is made early, thus avoiding complications, the result of treatment should be favorable.

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GROUP PRACTICE*

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YEARS ago, in San Francisco, the somewhat novel idea that water might have some usefulness as a beverage was discussed before the shining rail. The matter was summed up and disposed of by Ambrose Beirce, who conceded that there was something to be said in favor of water and something against it. In its favor was the undeniable fact that it was cheap; against it was the general agreement that it was not good. Many physicians maintain the same fair-minded attitude to group practice. Only the changing tempo of the times, it is to be supposed, justifies the suggestion that the traditions of the practice of medicine, old, eternal as the pyramids, be cast aside for newfangled methods. But though group practice of medicine is not new, and not uncommon, there are remarkably few reports published on the subject. Perhaps this fact, and fifteen years of not untroubled experience with the method, justifies this dissertation.

I will not pause for a definition, or a description of type and size. You are as familiar with the varied aspects in which group practice presents itself as am I. An attempt will be made to point out the advantages and disadvantages, theoretical and actual, of the method whereby a group of doctors pool income and expense, and practice in close association with one another.

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* Chairman's Address. Read before the Section on General Medicine at the seventieth annual session of the California Medical Association, Del Monte, May 5-8, 1941.

SOME ADVANTAGES

There are professional and financial advantages to the doctor in this device. It permits, even in small towns, a high degree of specialization, makes possible easy and utterly frank consultation without expense to the patient, provides a comforting check on the possibility of error and a friendly support in adversity, removes to a large degree the necessity for competition. The various members do a great deal toward the education of each other, the exchange of ideas tends to keep all members on their toes in order to be able to contribute to the various staff meetings, creditably. The introduction every few years of young men fresh from the schools and with specialized training tends to keep the older men informed of new developments and prevents dry rot. The experience of the older men communicated to the juniors tends toward a desiccation of the postauricular region.

There are financial advantages to the doctor. His overhead per man can be reduced, his income in sickness, in vacations, in old age, can be stabilized. He knows pretty well what each year will bring. He is not exposed to the ravages of the wolves who prey upon his flank when he leaves it unguarded for a long vacation. (We take six months with full pay every six years). A group can have a lay business manager, and the members be freed from all financial dealings with the patients. Their own personal affairs, taxes, etc., can be handled by this agency to their great advantage. The young doctor, highly trained, can be given an immediate living because enough work can be sent to him by the group to justify it. The group can have good laboratory help, a physiotherapist, an x-ray plant, etc., which the individual could not afford.

DISADVANTAGES

There are thorns on the rose. The group member will not in general achieve the eminent place as a consultant, due to the reluctance of "outsiders" to refer to a member of a group. The man with potentially a tremendous earning power will see some of it shaved off and given to the member whose work, though necessary and difficult, is not so remunerative. The group member must suffer from the mistakes and errors, both personal and professional, of his associates, and at times take a rap for another's fault. He must curb his individualism at times in the interests of peace and harmony. At times, he must stand for the expenses incurred by his partners, and at times he must submit to restraint in his own expenditures. If there is poor management, his own successful work may be nullified by the lack of success of an associate, or overhead may be allowed to mount beyond all reason and beyond his control. He may find himself in association with men he dislikes; he may find it impossible to agree upon a division of the spoils.

THE POOR PATIENT

The poor patient, who makes all this possible, deserves to be considered, and for him there is both a light and a dark side. He can get a more complete medical service. Even in a small community, it may be possible for him to have the services of a specialist when one is needed. And in this day and time, scientific competence is really for the first time getting ahead of instinct and a loudly understanding manner. The patient's time, as well as his money, are saved. He is not run all over the town when consultations are needed, or laboratory work to be done. He is not left on the limb when his doctor must rest. His records are available to the other members and, often, they are also known to him. He is assured of having someone on hand at all times to care for him. If he is a stranger, the name of a well-established group may enable him to get competent attention when he could not have found it in an individual M. D.

But, on the other hand, the old, sentimental doctor relationship may be broken up and the patient may find himself cut apart and divided arbitrarily between a committee. He may like the internist and loathe the surgeon in a group, and be unable to take one without the other. He may be subjected to cold-blooded business treatment at the hands of the manager. He may have to pay for the maintenance of all the specialists, when all he needs is a little general help. He may be subjected to unnecessary refers and specialized work just because the men are there. He may resent being amalgamated in a mill; there may be a feeling he is being robbed of the individualized care he wants. He may feel "pushed around." So it goes—something on both sides.

ON WHAT DOES SUCCESS DEPEND?

The success of the group depends primarily on the caliber of the men in it and upon their mutual trust and confidence in each other. Many concessions are necessary between the men if it is to work. There must be generosity and lack of avarice on the financial side. Most groups which smash up do so because of money fights. There are times when one man does more than he should, and he must be willing to for the sake of all. Various arrangements are made for the division of income. Some clinics give their senior men a fixed frozen income and let the juniors split the rest. Some provide the same income for each man without reference to his contribution. Some give a percentage to each, in theoretical keeping with his contribution. I believe this last method is less likely to give trouble, once the percentages are agreed upon. In most clinics, the younger men work on salaries during a probationary period in much the same way as in a law firm. After this period they usually go on percentage. It seems better to maintain a system of remuneration which corresponds to the production as nearly as possible.

COMMENT

No system is perfect. I believe, in the light of present social and socialistic tendencies, great changes are coming to us. And one of the ways in which we can meet them is by being ready in advance. The private groups, properly organized and controlled, may be one means by which the control of medicine can be kept in private hands. It is likely that for a great part of the country, we

shall see practice based on hospitals in the radius of about thirty miles, or in areas of about 20,000 population—that the doctors will have their offices in the hospitals and practice from them; that these doctors will have some necessary association with each other and with the hospital. I believe that more and more group systems will be set up.

ATTITUDE OF THE AMERICAN MEDICAL ASSOCIATION TOWARD GROUP PRACTICE

While the American Medical Association has made few official declarations of its attitude toward group practice, there is enough record to show a shift from antagonism toward something more than toleration during the last fourteen years. In 1927, Dr. Morris Fishbein formally declared that group practice experiments had usually failed and would doubtless continue to do so, since business methods and the practice of medicine were wholly incompatible.[1] This official view received a shock in 1931, when C. Rufus Rorem, under the auspices of the Committee on the Cost of Medical Care, published a study showing that there were over seventy-five successful group medical practice plans offering better medical service at less per unit cost to the patient.[2] In 1932, the report of the Committee on the Cost of Medical Care was published. The majority of committee members strongly favored group practice. The minority report less enthusiastically favored it under limited conditions. To this the American Medical Association responded in an emotional editorial, condemning the Committee on the Cost of Medical Care report as inciting "socialism, communism, and revolution," in spite of the fact that the Committee on the Cost of Medical Care was chairmanned by a former American Medical Association president, and a member of President Hoover's cabinet.

Since 1932, the American Medical Association's attitude has been noticeably modified. In 1933 the Bureau of Medical Economics of the American Medical Association published a study recognizing the existence of many successful group practice plans, which grudgingly admitted that group practice presented possibilities for better medical service.[3] This same bureau is currently making another survey of group practice in the United States. In 1935 the Bureau issued a pamphlet, entitled "New Forms of Medical Practice," which was very critical of all schemes of group practice, group health insurance, etc.[4]

Extensive investigations into the attitude of many doctors, made by the American Foundation, showed that by no means all the profession agreed with the views expressed in official American Medical Association publications.[5]

It will be recalled that in 1934 the Los Angeles County Medical Society expelled two members for alleged solicitation of patients in connection with their prepayment plan. This expulsion was upheld by the Council of the California Medical Association. But in January, 1936, the Judicial Council of the American Medical Association declared the expulsion void.

In 1939, the Bureau of Medical Economics of the American Medical Association published another study of various experiments in group medical care, which reflected a much more sympathetic view.[6] The new platform of organized medicine adopted officially in 1939 and outlined in the eight points carried on the editorial page of the *Journal* reflects a much more liberal view than the one of ten years before. Points six and seven of this platform at least intimate a more favorable view toward the achievements, functions, and future of group medical practice.[7]

I

ADVANTAGES OF GROUP PRACTICE: TO THE PHYSICIAN MEMBERS

I. *Economy of Operations.*—On overhead, office rent, purchase price, and depreciation of office equipment, a definite economy is obtainable under the group arrangement. This makes for more net profit, or income.

Reduction of the per doctor cost of office management expense.

The group enables the use of responsible, trained, lay managership for the handling of all business matters. This effects savings in expenses by controlled purchasing of supplies, both medical and nonmedical.

Reduction of pay-roll expense per doctor. (The clinic is 17 per cent below the average pay-roll cost per doctor for the general average of specialists in the United States. See Medical Economics for February, 1941.)

II. *Vacations and Leaves of Absence.* — Provides opportunity for suitable vacations and leaves of absence, for rest, and more study and research, without loss of income or loss of practice.

Individual doctors incur loss of income when away from their active practice. Any extended absence from practice not only stops their income, but also endangers their practice. (See Group Practice, page 3.)

III. *Protection of Physician Member's Family.* The possibility of greater income security to heirs and families of partners in case of partner's death.

Arrangements are possible under a group practice arrangement assuring continuance of income to a family or heirs for some time after a partner's death.

IV. *Less Competition.*—Comparative relief from the disconcerting influence of competition which any individual practitioner must face.

V. *More Work for Specialist Members.*—The free interchange of consultation reference between specialists in the group.

This tends to assure a volume of business to each specialist member of the group.

Individual practitioners seem reticent to refer cases unless absolutely necessary, for fear of losing the referred patient. (See Group Practice, page 3, *et seq.*)

VI. *More Assurance of Income with Advancing Years.*—Provides friendly help without economic loss to the older members of the group as they begin to slow down physically (with age).

VII. *Greater Opportunities for Younger Members.*—Provides adequate opportunity for the best and expensively trained young doctor.

This makes the young doctor's services available and offers him a decent living wage. (See Hugh Cabot, "The Patient's Dilemma," and Hugh Cabot, "The Doctor's Bill.")

VIII. *Personal Relationships Promoted.*—The professional and personal friendship between members of the group.

The opportunity for younger members to benefit from the guidance of their elders.

IX. *Fewer Business Distractions.*—The group arrangement enables individual doctors to be relieved from the care of business details.

The manager's office can relieve the doctors of all embarrassing financial relations with the patients by caring for all billing and collections.

X. *Stimulus for Best Type of Work.*—The group arrangement encourages each individual member to be more on his toes professionally.

XI. *Accessory Professional Aids Available.*—Economy of operations, as per Item I, above, enables members of the group to have available more adequate laboratory, x-ray, physiotherapy, etc., than most individual practitioners could afford.

The possible profits from the operation of these services is lost to the individual practitioner when he sends work to outside laboratories.

XII. *Permits More Adequate Service to Patient.*—The reduction per unit cost of medical care by group practice, enables the group to offer better and more adequate care to the patient at no additional total expense to the patient.

XIII. *Promotes Better Specialization.*—Group practice enables members to achieve higher degree of specialization and thus more effectiveness in the treatment of patients. (See Group Practice, page 4, *et seq.*, and Bernheim.)

XIV. *Enhances Community's Reputation as a Medical Center.*—The improved excellence of medical care facilitated by group practice enhances the general reputation of the community as a medical center and draws patients from wider areas.

XV. *Promotes Preventive Medicine.*—Group practice enables greater attention to preventive medicine, in keeping with the latest trends in medical thought. (See Bernheim, Cabot, Finney, etc.)

XVI. *To summarize*—Group practice will probably be the medical professional's best tool for meeting new conditions.

II

DISADVANTAGES OF GROUP PRACTICE: FOR PHYSICIAN MEMBERS

I. *Increased Moral and Financial Liabilities.*—The increased moral and financial liability each doctor carries for all his associates in the group.

This can include not only professional mistakes, but also indiscreet, nonprofessional acts of members of the group; acts of one can reflect on all members of the group individually and on the group as a whole.

II. *Strained Relationships Between Group Members and Profession at Large.*—Likelihood of embarrassed or strained relations between members of the group and other doctors in the community.

This seems to arise frequently and may be due in part to the independent practitioner's fear that the group is stealing, or will steal, his patients. Also, there seems to be a tendency toward jealousy resulting from the success of the group. (See Group Practice, page 4, *et seq.*)

III. *Overspecialization.*—Group practice may tend to encourage too high a degree of specialization by each member of the group.

It is reported members of groups have a tendency to insist that the patient he sees first has some ailment falling within his special field. (See Group Practice.)

IV. *Strained Relationships Within the Group.*—The possibility of dissension and quarreling among members of the group.

V. *Coöperative Responsibilities May Clash with Individual Tendencies.*—Group practice with necessary coöperative responsibilities may prove irksome to a strongly individualistic doctor.

Group practice must necessarily limit the complete independence of each member, who must consider the welfare and interests of the group as a whole.

VI. *Financial Reward May Be Less.*—Group affiliation and responsibilities might limit the income of an outstanding practitioner.

VII. *Group Procedures May Inconvenience Patients.*—In a busy group-practice office, patients may be kept waiting too long at the time of the appointment.

This may be true in the office of a busy private practitioner. However, it seems more likely to arise in a group-practice office, where the problems of management are more complex and thus more likely to show weaknesses leading to the above results.

VIII. *Patients May Have Less Freedom of Choice.*—The patient's freedom of choice of a doctor may be limited by rules of the group, forcing him to see the doctor thought by the group best able to treat his particular ailment.

This can be partially protected against by allowing the patient complete freedom of choice at first and sending him to other members of the group for consultation, without additional charge. (See Cabot, "The Patient's Dilemma.")

III

ADVANTAGES OF GROUP PRACTICE: TO THE PATIENT

I. *Better Medical Care for the Same Total Cost.* This means an actual reduction of the cost of medical care, since group practice can offer fuller, more adequate medical care for the same total cost to the patient. (See Group Practice, Bureau of Medical Economics, A. M. A., page 2.)

Economies in operation, made possible by group practice, enable the group to offer fuller service, treatment, and diagnosis without additional charge to the patient. This is true, because group practice economies of operations reduces the per unit cost of medical care.

It is argued that group practice should reduce the cost of medical care to the patient. It does, and should do so, in the sense stated above.

The group can hardly be much concerned with or expected to reduce the total cost of medical care, since the number of units of medical care varies so greatly from patient to patient. There is also great variance in the number of units of care due to changing schools of thought within the profession itself. Hence, the clinic, or group, can only concern itself with the cost per unit of care, and with the problem of how many units are really needed for each individual patient.

II. *Convenience to the Patient of Full Medical Services in One Place.*—This may be not only a convenience, but also a saving in cost of medical care to the patient, inasmuch as his time is saved.

III. *Assurance to the Patient of Adequate and Full Consultation of Specialists for the Proper Diagnosis and Treatment of His Care.*—Private practitioners may hesitate to refer cases for fear of losing them to the consultant. This does not arise in case of a properly run group.

IV. *Patient Is Offered a Better Type of Service.* The patient is offered a higher type of care resulting from the mutual stimulation between doctors of the group.

V. *Promotes Ease in Handling Financial Accounts of Patients.*—A more convenient and perhaps easier method of settling the charges for medical service. This matter can be cleared through the manager's office, if it is properly equipped to deal with credit problems.

VI. *Assurance of Adequate Care at All Times.* Assurance to each clinic patient of adequate medical care *all* the time, regardless of vacations, sickness, etc.

VII. *Group Gives Assurance to Strangers in the Community.*—The existence of a well-established clinical group in the community offers to a stranger assurance of reliable and adequate medical care.

A stranger in the community can feel more certain of getting adequate treatment in applying to an established group than if he had to select a single practitioner who might or might not be properly equipped to treat his ailments.

VIII. *Patient May Expect Better Medical Care.* Better medical care may be expected by the patient, since the group can afford to pay more attention to preventive medicine, as the latest thought in the profession favors. (Cabot, "The Patient's Dilemma.")

The improved excellence of professional services available to any patient applying to the group for medical care.

This stems from the conveniently collected number of highly qualified specialists, etc.

Under this heading comes the point discussed under number VII, of advantages to doctors. Many communities can or could be offered services of highly trained young men at costs which the patient can stand. These services would not be available to such communities under private practice arrangements, because the highly trained young men could not make a living if they had to meet the problems of private individual practice.

IX. *Group Practice Promotes Other Interests in the Community.*—The improved excellence of medical care facilitated by group practice improves the community, draws business, both medical and nonmedical, from wider areas.

IV

DISADVANTAGES OF GROUP PRACTICE: FOR THE PATIENT

I. *Lessens Intimacy of Physician-Patient Relationship.*—The possibility of the interruption of desirable close relationship between the patient and the doctor of his choice.

This may be caused by the tendency toward mechanization in the case of group practice.

II. *Interchange of Group Members May Not Be Acceptable.*—The possibility that the patient may be referred by one member of the group to another group member who may be distasteful to the patient.

III. *Patient May Object to Business Office.*—Patients may dislike doing business with the manager's office regarding payment of accounts.

This can be ameliorated by leaving part of the matter of bill settlement in the hands of the doctor who performed the services.

IV. *Costs of Care May Be Too Great.*—The possibility of the increased total costs of medical care assessed against the patient by the medical group.

This is because of the alleged tendency in group practice toward overelaboration of medical care. (See Group Medicine.)

This subject is also related to the issue of per unit cost of medical care discussed under Item I, of Advantages to Patients.

This is also related to the subject discussed under Item VII, of Disadvantages for Doctors.

V. *Group Practice May Be Lacking in Individual Care.*—In a busy group-practice office, patients may get the impression they are being run through a mill, becoming subjects of mass production methods.

Especially wealthy patients sometimes feel they do not receive enough individual attention from a doctor in a group.

VI. *Mechanized Nature Emphasizes Medical Science Rather Than Medical Art.*—Tendency toward purely "scientific" treatment of patients tends to make group practice more of a mechanized science, thus interfering with the *art* of medical practice.

VII. *Overequipment of Group May Lead to Excess Costs.*—If not properly managed, a group can actually increase the per unit cost of medical care and the total cost to the patient.

This point is in part related to the alleged tendency of groups to go in for too much equipment, and then overservice and overcharge the patient in order to carry the heavy overhead. This causes unfavorable public reaction toward the group. (See Group Practice.)

VIII. *Business Manager Not Conducive to Physician-Patient Relationship.*—Presence of busi-

ness manager, a layman untrained in medical ethics, may prove a disturbing element in the doctor-patient relationship. (See Group Practice, page 10, *et seq.*)

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SYNTHETIC ESTROGENS: CLINICAL EXPERIENCES WITH SOME OF THE NEWER FORMS*

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ESTROGENIC hormones, obtained from extraction of animal ovaries or human female urine or placenta, have been employed for many years with varying degrees of success; the indications being, chiefly, the menopause, disturbances of menstruation, retarded or inadequate sexual development, senile vaginitis and pruritus, and involutional melancholia. Ovarian extracts, like other endocrine derivatives, may not exert precisely similar effects in different species, so that experimental results cannot always be duplicated in the human being. Moreover, two individuals may not react in identical fashion to the same dosage, even though they appear to be suffering from the same symptoms. This uncertainty of response may have been due partly to some instability of the extracts themselves, with consequent variability and diminished potency; and, also, to different and often quite dissimilar biologic standards employed by numerous manufacturers, making comparisons as to dosage and effectiveness debatable and confusing.

DOSAGE NOMENCLATURE

Discovery of the chemical composition of the female sex hormone, and, from a practical standpoint more important still, its synthesis, has afforded a welcome clarification of the previous chaos. The several chemical substances to be discussed possess the merit of constancy, uniformity, unquestioned potency, and apparently permanent stability. Furthermore, these crystalline preparations are measured in milligrams, a dosage language more familiar and more readily comprehensible to the average physician than the former somewhat bewildering, and almost awesome, designation of thousands of international units, which were apt to convey a formidable impression of strength, when actually they were much weaker (in the amounts ordinarily administered) than the "comparatively tiny" milligram. On top of this misapprehension we must not forget the perplexity which ensues in attempting to evaluate and correlate preparations variously standardized in rat units, mouse units, rabbit units, "effective" units, etc.

ACTION OF ESTROGENIC HORMONES

Estrogenic hormones are capable of: (1) producing "estrin withdrawal bleeding"; (2) generating an intermenstrual type of endometrium; (3) inducing growth of the hypoplastic uterus; (4) relieving the symptoms of the menopause; (5) converting a "menopausal" into an "estrous" type of vaginal smear; (6) restoring the normal appearance of the vulva and vagina when these have become atrophic as the result of the estrogenic deficiency of the climacteric; (7) causing painful swelling of the breasts; (8) influencing proliferation and activation of the epithelium of the mammary glands; and (9) relieving the pain of dysmenorrhea.

The limited time for presentation does not permit, nor do the scope and purpose of this communication require any reference to the literature of this subject; some of it already is quite extensive.

CONCERNING CASES REPORTED

We have selected, from our respective clinic and private practices and those of our associates, one or more cases, for each of the synthetic estrogens, sufficiently spectacular in their response to treatment as to constitute convincing testimony to the powerful potency of these new hormones. From an extensive experience over many years, we are inclined to doubt the likelihood of achieving similar success with the extracts heretofore available. We are not including treatment of the menopause and its complications, since these were handled satisfactorily, as a rule, before the advent of synthetic estrogens.

REPORT OF CASES

Case 1. *Implantation of Estradiol Benzoate Into a Sexually Infantile Girl Aged Twenty-Three Years.*—Her mother had matured at thirteen years of age, and the patient's two sisters both matured before their fourteenth birthday. The mother, father, and both sisters are of normal stature.

The patient's height, at the age of twenty-three years, was only 4 feet 4¾ inches, and she weighed 76 pounds. There would have been nothing unusual about her general appearance if she had been, say, twelve years of age; she was a petite girl who was normally proportioned. However, for twenty-three years she was glaringly retarded sexually and skeletally. The chest wall was absolutely flat and no mammary tissue was palpable. There was no axillary hair whatever, and the pubic hair was exceedingly sparse and limited to the labia. Rectal palpation revealed a uterus which was infantile in size. Laboratory tests resulted in a basal metabolic rate of 14 per cent plus; and

* Read before the Section on General Medicine at the seventieth annual session of the California Medical Association, Del Monte, May 5–8, 1941.

February 13, 1940 April 22, 1940 October 8, 1940

Fig. 1 (Case 1).—H. P. Single girl, age 23 years. Had never menstruated. Two sisters matured at 14 years. Height: 4 feet, 4¾ inches. Weight: 76 pounds. All epiphyses closed. February 29, 1940: Implanation of 9 pellets Estradiol Benzoate, totaling 56.7 mgms. Note rapid breast development following implantation. Menarche: April 25 to May 2, 1940 (8 weeks after implantation). Subsequent periods: May 30 to June 6; June 25 to July 5; August 13 to August 25; September 15 to September 21; and October 15 to December 8, 1940.

x-ray bone age of between eighteen and nineteen years; the glucose tolerance test, blood count, and urinalysis were normal; Wassermann was negative.

She had been treated with various endocrine preparations over the past six years. For two years, in an attempt to stimulate growth, she had received anterior pituitary grains 15, daily, in salol-coated capsules. During the next year she received this same preparation and, in addition, chorionic gonadotropic hormone, 50 rat units, by hypodermic, three times a week. During the succeeding year and a half she received Squibb's Anterior Pituitary Extract, one cubic centimeter by hypodermic, six times a week; for the following year and a half she received theelin, 2,000 units by hypodermic, three times a week. Improvement under these treatments was negligible, for after this six years' therapy she had grown but 2¼ inches, and there was no evidence of development so far as her primary and secondary sex characteristics were concerned.

At this time she received a subcutaneous implantation of nine pellets of estradiol benzoate, totaling 56.7 milligrams. No other treatment was administered.*

Three weeks after this implantation there was definite and unmistakable evidence of mammary development, and the patient stated that the breasts had been sore to touch since four days after the implant. This remarkable rapid breast growth progressed, and within fifty-two days after the implant she showed the degree of maturity revealed by these photographs (see Fig. 1). It will be noted, also, that there was some increase in the amount of pubic hair, but as yet no axillary growth.

The menarche was established just eight weeks after the implantation. The first period lasted for eight days, was moderate in amount and without discomfort. During the next five months she had four menstrual periods at intervals varying from twenty-six to forty-nine days. The sixth period began thirty days later and persisted for seven weeks. At this time it was thought advisable to do a diagnostic curettement—this revealed an endometrium in the follicular phase. Since a small mass remained at the site of the implantation, we removed it and recovered 16 milligrams of estradiol benzoate imbedded in a rather thick fibrous capsule. It is interesting to note that the patient has had no menstrual periods since the removal of this hormone remnant five months ago, although she has diffuse lower abdominal cramps occasionally which are accompanied by nausea and vomiting; these episodes have occurred at monthly intervals and persist for from two to four days.

* The estradiol benzoate crystals were generously furnished by the Ciba Company, and the material was prepared and implanted by Dr. G. R. Biskind.

Estradiol benzoate is the most potent of the synthetic estrogens produced to date; it has a rather prolonged effect. Estradiol dipropionate has an even greater prolonged action, but is considerably less potent.

Estradiol dipropionate is a sterol compound. It was isolated from the ovaries in crystalline form. The dipropionate is the di-ester of alpha estradiol esterfied with propionic acid. It is a chemically pure substance. One milligram is equivalent, supposedly, to about 50,000 international units of theelin. Because of its prolonged action, three to five weeks, estradiol dipropionate is extremely practical in controlling menopausal cases as injections need be given at relatively infrequent intervals. It is not effective orally. One investigator found, in a large series of cases, that he was able to curb menopausal symptoms on the following schedule:

21 patients by treatment once a week
3 patients by treatment every ten days
25 patients by treatment every two weeks
6 patients by treatment every three or four weeks.

Our experience with a smaller series has been quite comparable, although most of our cases required treatment every seven to ten days.

* * *

Case 2. *Induction of Menarche and Development of Secondary Sex Characteristics in a Woman Aged Thirty-Four by Injections of Estradiol Dipropionate.** † — This woman showed the disproportionately long extremities characteristic of a pre-adolescent eunuchoid, and at the age of thirty-four years x-ray bone-age studies showed that some of her epiphyses were still open. Her breasts were very small, axillary and pubic hair were sparse, and the uterus was infantile. She had never menstruated. Estradiol dipropionate was administered, but because she was one of our first cases treated with this hormone the original doses were too small. The dosage at first was 0.1 milli-

* The estradiol dipropionate used in this case was furnished by the Ciba Company. Their trade-name for this product is Di-Ovocylin.

† Published in greater detail by R. F. Escamilla and H. Lisser in *Endocrinology*, vol. 27, page 152, 1940.

gram by hypodermic, three times a week. After five weeks this dose was doubled, and one month later it was increased to 2.5 milligrams three times a week. Five months after treatment was started she had her first menstrual period; this was of thirteen days' duration. The dosage was then reduced to 5 milligrams once a week. Three months later the second period occurred. Neither period could be construed as "withdrawal bleeding," for she was still under active treatment. There was further evidence of maturity in that the breasts became larger and there was considerable growth of axillary and pubic hair.

* * *

Case 3. *Resumption of Menstruation in a Woman Aged Thirty-Eight, After Twenty-Three Years' Amenorrhea, by Oral Administration of Ethinyl Estradiol.*—This patient when thirty-eight years old came under the care of Dr. H. Clare Shepardson, who has kindly permitted us to publish the results of treatment with ethinyl estradiol. This synthetic estrogen is active orally; it is not as yet available commercially.* Her menarche occurred at the age of thirteen years and she menstruated regularly until fifteen years of age. At that time she fell out of a swing and, although she suffered no serious injury, menstruation ceased and amenorrhea persisted for the next twenty-three years. Examination revealed a woman 69¼ inches tall, who was obese and had disproportionately long extremities. Her span was 72 inches; upper measurement 29¾ inches and lower measurement, 39½ inches. The breasts had atrophied completely and no mammary tissue was palpable; the uterus and cervix were quite small. Her basal metabolic rate was 17 per cent minus.

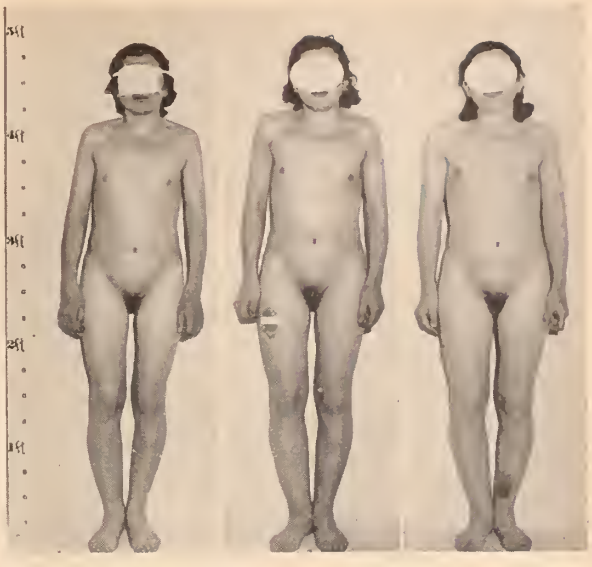
She was put on thyroid, U. S. P., grains one daily, and on alpha estradiol orally. After three months of this treatment (54,000 units of alpha estradiol) there was definite breast development, but no change in the pelvic organs. The basal metabolic rate had been elevated to 2 per cent plus.

She then was started on ethinyl estradiol, 0.15 milligrams, three times a day, orally. Within three weeks she had a menstrual period lasting six days. The breasts became sore before the period and improved soon after the onset of flow. The manufacturer subsequently reduced the strength of the tablets to 0.05 milligrams, which dosage has been continued three times a day, orally. She has had four normal menstrual periods while on ethinyl estradiol, and there has been marked development of breast tissue. This resumption of menstrual periods after twenty-three years' amenorrhea is quite remarkable, and is convincing evidence of the estrogenic potency of this hormone.

STILBESTROL

In 1938, Dodds and his coworkers in England synthesized diethylstilbene and demonstrated that, although it did not contain the phenanthrene ring, formerly thought necessary for estrogenic activity, it was a potent preparation with all the properties of true estrogenic hormones. It is three to four times as powerful as naturally occurring estrone, and it is about 50 per cent as potent orally as parenterally, contrasted with estrones and estrogens, which lose about 90 per cent of their activity when given by mouth (the latter, probably, are inactivated by the liver). Its low cost is a tremendous advantage when considering estrogenic therapy where continued treatment over a long period of time often is necessary. The average dose is about one milligram daily, although there are many reports of daily amounts up to 30 milligrams, and Priscilla White reported the use of 100 milligrams daily in diabetic women who were pregnant.

Unfortunately, stilbestrol therapy is not devoid of toxic side-effects, which include nausea, vomiting, abdominal distress, anorexia, drowsiness, lethargy, paresthesias, vertigo, thirst, acute psychoses, cutaneous rashes and, possibly, liver damage. The incidence of these unpleasant disadvantages, according to numerous investigators, has shown an amazing discrepancy, ranging from a relatively negligible 5 per cent, to one report of 80 per cent of all patients receiving this medication. It is difficult to reconcile such widely disparate experiences, although data have been reported suggesting some relationship between the size of the dose and toxic effects. It may be noted that stilbestrol has been used most extensively in patients suffering from the menopause, who are notorious for varied and sometimes bizarre symptoms and reactions, which possibly might have occurred either with or without therapy of any sort.



June 8, 1939 January 2, 1940 July 8, 1940

Fig. 2 (Case 4).—B. H., age 30 years. Had never menstruated. Note scant pubic hair and immature breasts. Treated with stilbestrol, 1 mgm. by hypo., 3 times per week. After 4 months, treatment was changed to oral route, giving 1 to 3 mgm. daily. Menarche established 4 months after starting treatment. Note definite breast development, also marked pigmentation of nipples and areolae.

Nausea may occur, whether the medication is given orally or by hypodermic. There have been some reports suggesting that plain tablets are more likely to produce unpleasant reactions than when they are enteric-coated. This has not been the universal experience. It is the writer's custom to prescribe the full daily dose at bedtime in an attempt to reduce the frequency of reactions. This was notably unsuccessful in one of our cases. This patient was given a dose of stilbestrol by hypodermic upon retiring. Some five hours later she was roused from a sound sleep because of nausea, which progressed to the point where vomiting ensued. The reaction in most instances is probably central in origin and not produced locally in the intestinal tract.

One of our clinic associates, Doctor Goldberg, has mentioned symptoms of an unpleasant character, simulating pregnancy, and one of the authors (H. L.) has called attention to the deep pigmentation of nipples and breast areolae in a woman receiving stilbestrol.

* The ethinyl estradiol used by this patient came from a generous supply furnished by the Schering Corporation.

This synthetic estrogen has not been released as yet in the United States, although it can be obtained on prescription both in England and Canada. It is to be hoped that it will be available before long because of the convenience of oral potency, and its relative inexpensiveness.

* * *

CASE 4. *Induction of Menarche and Development of Secondary Sexual Characteristics in a Woman Aged Thirty, by Injections and Later Oral Administration of Stilbestrol.*—This patient, though thirty years of age, was but 59 inches tall, had scant axillary and pubic hair, childish breasts, and had never menstruated. She was given stilbestrol [1] by hypodermic, starting with 0.2 milligrams and gradually increasing to 1 milligram three times a week. After four months' treatment she had her first menstrual period. At this time we switched to 2 milligram daily by mouth and, before long, menstrual periods occurred fairly regularly. She gained 13 pounds in ten months, and breast development was gratifying (see Fig. 2).

* * *

CASE 5. *Pregnancy in a Woman Aged Twenty-Seven, by Oral Stilbestrol Therapy, Who Had Been Amenorrheic for Twenty-Two Months.*—She had matured at the age of seventeen years, and had menstruated regularly every twenty-eight days until she became pregnant—but had not menstruated since the normal delivery of her child twenty-two months before. She was 62 inches tall and weighed 103 pounds. Her breasts were very small for a woman who had borne a child; she had no axillary hair and the pubic hair was sparse. The uterus appeared to be somewhat small. Routine laboratory tests were within normal limits. The probable diagnosis seemed to be pre-adolescent hypophyseal deficiency as suggested by delayed maturity at seventeen years, with relapse into her former state after the one pregnancy at twenty-five.

She was put on stilbestrol [2] orally, starting with one milligram and gradually increasing to two and finally three milligrams daily. After four months of treatment her menstrual periods had not returned, but she came into the office complaining of fullness of the breasts and some nausea. The patient said she felt as though she were pregnant again. Examination revealed a slightly enlarged uterus. She was sent to an obstetrician, who delivered her of a full-term baby some eight months later. It is interesting that when the patient was told she was pregnant, she remarked that her sole reason for seeking treatment for the amenorrhea was because she feared another pregnancy was impossible unless her menstrual periods returned. Her menstrual periods have been perfectly normal since this last confinement.

* * *

CASE 6. *Feminization and Demasculinization of a Seventeen-Year-Old Girl by Injections of Stilbestrol.* [3] †—This girl already had a markedly hypertrophied clitoris at birth. At the age of seven years she was subjected to an exploratory laparotomy, to determine the status of her internal genitalia—tiny ovaries and a uterus were found, and therefore the clitoris was amputated. When sixteen years eight months old, she was still immature; she had not menstruated. There was no breast development whatever and the uterus felt infantile. Hypertrichosis was luxuriant and of heterosexual character. The clitoris "stump" was as large as the terminal phalanx of a thumb.

Stilbestrol was injected, 0.2 milligrams, three times a week; this dosage was increased gradually to one milligram at the same intervals. Within the first month, breast development was obvious and after four months she had her first menstrual period. By this time the breasts were well formed and of adult size. The nipples showed the deep pigmentation previously referred to. The abnormal hair paled, and in the course of a year the masculine hypertrichosis disappeared. The clitoris remnant atrophied to one-quarter its former size. Thus she was feminized and demasculinized. Subsequent stilbestrol therapy, switched to one milligram daily, orally, has maintained the transformation, and menstrual periods continue to recur fairly regularly.

1 The stilbestrol used in this case was furnished by Eli Lilly and Company.

2 The stilbestrol used in this case was furnished by the Winthrop Chemical Company.

3 The stilbestrol used in this case was furnished by E. R. Squibb and Sons.

† Published in greater detail by H. Lisser in *Endocrinology*, vol. 27, page 385, 1940.

CONCLUSIONS

With the introduction of synthetic estrogenic hormones two important factors, viz., variations in standardization and uncertainty in respect to stability, have been banished. Dosage is expressed in milligrams instead of units.

A case is reported in which remarkable results were obtained by implantation of estradiol benzoate in a 23-year-old girl of short stature, who almost totally lacked primary and secondary sex characteristics.

Estradiol dipropionate has been demonstrated to have a prolonged action and, therefore, offers a desirable advance in the treatment of the menopausal syndrome, since injections need not be given at such frequent intervals. A case is reported in which a 34-year-old woman who had never menstruated was normally matured.

Ethinyl estradiol has been shown to be remarkably effective orally. A case is reported of a 38-year-old woman who was cured of twenty-three years' amenorrhea.

Stilbestrol possesses all the properties of true estrogenic hormones. It is effective both orally and parenterally, and is relatively inexpensive. Toxic reactions are reported to occur in widely divergent percentages, from negligible to as high as 80 per cent. These unpleasant side-effects, in our personal and clinic practices, have had a low incidence, about 5 per cent. Three cases are reported, illustrating, respectively, induction of menarche at thirty years of age; pregnancy after twenty-two months amenorrhea; and feminization and demasculinization of a 17-year-old girl.

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TRIBROMETHANOL NITROUS OXID ANESTHESIA: ITS USE IN THORACIC SURGERY*

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THE University State Tuberculosis Hospital is a unit of the University of Oregon Medical School and has been in operation for eighteen months. This hospital is primarily devoted to the treatment of patients who have a chance for rehabilitation through surgical procedures.

At about the time the new hospital was opened the surgical staff made more frequent use of electro-

* From the Division of Anesthesiology, University of Oregon Medical School, Hospitals and Clinics, Portland, Oregon.

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cautery for the control of bleeding during thoracic operations. This created a special problem for the anesthetists as it became necessary to provide fireproof anesthetic agents and methods for cases in which the cautery was to be employed. Prior to this time we had made frequent use of cyclopropane for thoracic operations with considerable satisfaction.

SAFEGUARDS

To meet this situation we have employed two methods which have worked out fairly well:

First, the intravenous administration of pentothal sodium accompanied by the inhalation of 100 per cent oxygen.

Second, a basal dose of tribromethanol supplemented as necessary by the inhalation of nitrous oxid oxygen mixtures. This method has become almost a routine procedure for cases in which the cautery is to be employed.

PROCEDURE

In regard to the use of pentothal sodium, I feel that the margin of safety is greatly increased by the simultaneous administration of oxygen from a gas machine. It has been our custom to place an airway and adjust the mask as soon as the patient is relaxed and to continue with 100 per cent oxygen throughout the anesthetic and surgical procedure.

Respiration may be readily judged by watching the breathing bag. The patient's color remains good throughout the procedure. Pressure on the breathing bag may overcome disturbances in respiration. I believe that oxygen administration is responsible for smoother, safer, and more readily controlled anesthesia. However, one disadvantage is that the services of two anesthetists may be required, one to inject the pentothal and another to manipulate the gas machine.

Tribromethanol nitrous oxid anesthesia is preceded by nembutal (pentobarbital sodium) grains 1½ and pantopon grains ¼ to ⅓ administered two hours and one hour respectively before the avertin enema. Our usual basal dose of avertin is 70 milligrams per kilo of bodyweight but this is reduced to 60 milligrams per kilo for poor risk cases.

The patient may be very drowsy upon arrival in the surgery and in some cases basal anesthesia is complete. If an airway is tolerated it is placed before the mask is adjusted. Nitrous oxid oxygen or oxygen alone is administered according to the need. It has been customary for the surgeon to infiltrate the area of incision with novocain. We have found that nitrous oxid may be necessary only for the early stages of operation, incision and costectomy, but the administration of oxygen is continued throughout the surgical procedure in every case.

COMMENT

This method has produced smooth anesthesia in the majority of cases and there has been little difficulty with obstruction of the airway. The operating table is placed in slight Trendelenburg position so that gravity will aid in the removal of excessive secretions. Intratracheal suction is attempted whenever indicated by a small urethral catheter passed by the nasal route. Adequate positive pressure has been obtained when needed by increased bag pressure with a tight fitting face mask.

Patients who have undergone major surgical procedures are always placed in an oxygen tent upon return to their ward and a blood transfusion is generally administered. The foot of the bed is slightly elevated and intrapharyngeal or intratracheal suction is applied if secretions accumulate.

SPECIAL CONDITIONS

Postoperative depression has been troublesome in only a few cases (four in this series) and all of these were poor risk patients, toxic from long standing suppurative disease of the lung. They all responded satisfactorily within six hours following operation.

Most of the patients have had a return of the cough reflex and have been able to respond intelligently to questions within an hour. They may be drowsy for three or four hours but are easily aroused. Some have required further sedation in the immediate postoperative period. Postoperative nausea and retching did not occur following avertin nitrous oxid whereas it was frequently present when cyclopropane was employed.

Extrapleural pneumolysis with pack [1] has been a common operative procedure for the treatment of pulmonary tuberculosis. Most of the candidates for this operation have been young or middle aged adults and more often than not they have been apparently in good physical condition—some even robust in appearance. Avertin nitrous oxid anesthesia has been particularly well tolerated in this group and the operation does not seem to produce shock.

In asthenic or toxic patients caution should be exercised as they are poor risks from both the anesthetic and surgical standpoints. I believe that a basal dose of avertin exceeding 60 milligrams per kilo is not entirely safe for patients suffering from long standing suppurative disease such as lung abscess, empyema, or bronchiectasis. These cases demand careful watching in the immediate postoperative period and the services of the anesthetist may be very important. Intratracheal suction, the administration of 100 per cent oxygen, and the proper use of analeptics may be life saving procedures for the depressed patient.

RESULTS

There have been 119 major procedures performed at the new Tuberculosis Unit since its opening eighteen months ago, which required other than local anesthesia. There have been no deaths directly attributable to the anesthetic agent or method. There was one death due to massive atelectasis of the sound lung which occurred on the sixth postoperative day. No deaths occurred under four days following the surgical procedure. The mortality rate directly or indirectly attributable to surgery has been 2.4 per cent and that occurred in far advanced cases. I believe that this is an enviable record from the surgical standpoint.

CHOICE OF ANESTHESIA AT THE UNIVERSITY TUBERCULOSIS HOSPITAL

Tribromethanol nitrous oxid was employed in fifty-seven cases as follows:

Extrapleural pack	31
Removal of pack	2
Extrapleural pneumothorax	2
Rib resection	1
Cauterization of incision	1
Thoracoplasty	13
Spinal fusion	1
Lobectomy	2
Segmental lobectomy	1
Thoracotomy	2
Muscle flap with thoracotomy	1

Pentothal sodium and oxygen was administered to five patients:

Extrapleural pack	2
Change drain tube	1
Thoracoplasty	1
Muscle flap	1

In the same period, eighteen months, avertin has been employed in nine thoracic operations at the Multnomah Unit of the University Group of hospitals and pentothal sodium has been utilized in three instances.

I have administered avertin seventeen times for thoracic procedures in other hospitals and pentothal sodium in four thoracic cases.

Our experience with tribromethanol supplemented with nitrous oxid oxygen totals eighty-three cases to date, and the use of pentothal sodium intravenously accompanied by the inhalation of 100 per cent oxygen has been tried in twelve various thoracic operations.

COMMENT

There has been considerable criticism of the use of tribromethanol or of pentothal in thoracic surgery. Beecher [2] states that the combination of avertin and nitrous oxid for use in thoracic surgery can only be condemned and that the employment of evipal and pentothal in major thoracic surgery is not one of the legitimate uses of these agents.

Decker in discussion of Beecher's paper [3] states that pentothal intravenously is much to be preferred to avertin and that the latter is considered a toxic and dangerous drug.

Eloesser in discussion of the same paper [4] states that avertin is a good anesthetic as far as the operation goes, but that avertin has always frightened him afterward because of the difficulty of arousing the patient.

Dunlop [5] believes that the action of avertin is too prolonged in chest operations; that it inhibits cough far into the postoperative period; and that it depresses the circulation and respiration.

I realize that the small number of cases reported herewith warrants only mention as a preliminary account. However, the thoracic surgeons at our institution have been pleased with the use of basal avertin and nitrous oxid in cases requiring the use of electro-cautery, and they wish us to give further trial to this method.

3329 South West Thirteenth Street.

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SULFANILAMIDE IN OPHTHALMOLOGY*

GEORGE P. LANDEGGER, M. D.
Los Angeles

OPHTHALMOLOGY being a small specialty in the healing art, it is only to be expected that any worth-while discovery in therapeutics in general will soon show its repercussion on our small field of endeavor.

Just as it was not long after Wagner-Jauregg in Vienna introduced fever treatment for the combat of syphilis, that oculists made use of this new concept of fighting disease in their particular field. We all are now familiar with the value of fever treatment and foreign protein therapy in shortening the course of keratitis, iritis, etc.

EARLY STUDIES

You have heard that sulfanilamide containing azo dyes are known and used in the dye industry since 1908. It was used against streptococcal infection first by Domagk in 1935, and he is rightly credited with the discovery of its therapeutic value. Whom to credit with the introduction of sulfanilamide in ophthalmology is not quite as easily stated. As far as I can make out, it was Hageman, a pediatrician in this country, who first reported the use of sulfanilamide in the treatment of ophthalmia neonatorum due to gonococci, and Heinemann, in the Dutch East Indies, who first used the drug successfully on trachomatous patients in the year 1937. Doctor Loe of the Indian Service in this country made his first extensive report on 140 trachoma cases at the American Medical Association convention in San Francisco in the summer of 1938. Having the advantage of hindsight, we should not be surprised that sulfanilamide influences eye diseases when we know that Bellows and Chinn reported that sulfanilamide can be detected in all ocular tissues within fifteen minutes after its oral administration. The maximum concentration of the drug in ocular tissue is reached after about six hours.

After these general and historical remarks, we wonder which particular eye conditions are chiefly benefited by this drug. The two outstanding diseases which are combated by sulfanilamide are gonorrheal conjunctivitis and trachoma.

GONORRHEAL OPHTHALMIA

Although there is no other group of people who are more apt to disagree than doctors of medicine, you will not find a single author in the medical

* Read before the Section on Eye, Ear, Nose and Throat, at the seventieth annual session of the California Medical Association, Del Monte, May 5-8, 1941.

literature about gonorrheal ophthalmia who is not struck by the dramatic therapeutic effect of this drug in this particular condition.

Not having had enough personal experience, I like to quote the article by Doctors Bower and Frank, from the Department of Contagious Diseases in the Los Angeles County Hospital:

> They treated twenty-one cases of bacteriologically proved gonorrheal ophthalmia with the *usual* local measures *and* sulfanilamide. Some eighteen responded successfully with a first negative eye smear after an average of two days. They were free of any clinical symptoms after an average of ten days. In all cases where the cornea was not involved at admission, vision was entirely preserved. In no case did corneal perforation occur. All of the three failures were in infants, two of whom were premature. One of the so-called failures had just a relapse after he was dismissed. On readmission the infection was promptly cured. The second failure was a four-pound baby, where the sulfanilamide had to be discontinued on the seventh day because of vomiting, so that the child really never got adequate doses. This child did eventually develop a badly scarred cornea. In the third unsatisfactory patient, the sulfanilamide was reduced to one-half the usual dose before smears were negative. This would permit the conclusion that if sulfanilamide can and is given in adequate doses, a relapse or corneal involvement will not occur.

These authors who had the experience in twenty-one patients, gave 15 grains of sulfanilamide for every twenty pounds of body weight, divided in six doses and given every four hours. About one-half of the 24-hour dose was given on admission. The concentration of sulfanilamide in the blood should be kept at about 5 milligrams per 100 cubic centimeters of blood. These maximum doses are given until negative eye smears are obtained. This dosage is then gradually decreased in a period of three days to about one-third the original amount and continued on the lower figure for another eight days. This is to prevent relapse. Complete blood counts were made daily and sodium bicarbonate was given by mouth in the same doses as sulfanilamide. The doses of 15 grains per twenty pounds of body weight is rather high, but it seems to be essential in infants who stand sulfanilamide much better. In adults, one-half the amount of grains per pound of body weight is usually sufficient. When given subcutaneously, a one per cent solution of sulfanilamide is used. One hundred cubic centimeters for every forty pounds of body weight is given every twelve hours. Naturally, the concentration in the blood also has to be checked and should be about 5 milligrams per 100 cubic centimeters, just as during the oral administration.

OTHER STUDIES

All other authors achieved just about the same results. Therefore, we can safely say that sulfanilamide reduces the length of gonorrheal ophthalmia from an average of twenty-seven to ten days. And, better still, while it took ordinarily twenty days to get a negative smear, it takes, with the aid of sulfanilamide, an average of only one-tenth of that time to get a negative smear. No corneal ulcer develops if the treatments are started before the cornea is involved. If the treatments are not started until after the cornea is involved, the result will be that much less favorable. Sulfathiazole can be substituted for sulfanilamide and used in the same dosage, and is usually less toxic.

TRACHOMA

The widest field in the use of sulfanilamide in ophthalmology is in trachoma. I mention it secondly because the results are not as uniformly good as in the Neisserian infection of the eye, and their evaluation is a little more complicated. Loe reported 140 cases in the Indian Service in 1938, and stated that all of them were cured. Forster, in 1940, reported, concerning 167 school children in an Indian school in Arizona, that the disease was arrested in all of them within six weeks. They all received one-half grain of sulfanilamide per pound of body weight, divided in four doses during the day for three to six weeks. We must remember that all those patients were children and most of them rather early cases of trachoma.

Thygeson reports, in his last series of thirty-one cases of trachoma treated with sulfanilamide, that sixteen were healed, eleven showed satisfactory improvement, and four exhibited little or no change. The drug appeared efficacious in the early cases and when employed in relatively high dosages, achieving a blood concentration of 5 milligrams per 100 cubic centimeters or higher. Healing was also obtained in certain long-standing cicatricial cases, in some of which low doses were given over a relatively long period of time. Histologically, sulfanilamide effected rapid disappearance of the epithelial cell inclusion characteristic of active trachoma, but had little effect on secondary bacterial infection caused by influenza bacilli, Diplococcus pneumoniae or Staphylococcus aureus. Corneal lesions responded rapidly and papillary hypertrophy regressed much more rapidly than follicular hypertrophy. Doctors Haley, A. E. Brown, and Herrell, from the Mayo Clinic, reported in June, 1940, that they treated eleven cases of trachoma with sulfanilamide. In three of these cases, treatment with neoprontosil was substituted for sulfanilamide, because the patient showed toxic effect from the drug. They state that the results of the cases treated with neoprontosil were not as rapid and dramatic as the ones treated with sulfanilamide, but just as good.

In contradiction to these favorable reports are some other smaller series, reported by oculists who refuse to be impressed by sulfanilamide in its effect on trachoma.

The February issue of the 1940 *Journal of Ophthalmology* contains a very interesting article by Doctors J. E. Smith, Julianelle, and Gamet. These writers report a series of twenty-six trachoma cases, which were treated with sulfanilamide internally. They found that thirteen—that is, one-half of them—did not show any change at the end of the treatment; eleven were improved, and in only two of them was the trachoma arrested. It is interesting to notice that fourteen out of the twenty-six patients had the trachoma for over ten years. They, undoubtedly, must have been in the third or fourth stage of trachoma when the symptomatology is dominated by old scars. Naturally, not

much of an improvement can be expected in cases of that type, and such cases cannot be compared with rather fresh trachoma in children. The doses of sulfanilamide these authors gave were smaller than the ones used, for instance in the last series of Doctor Forster. They gave only one-third grain per pound of body weight, so that the concentration of the drug in the blood ran around 4 milligrams for the first ten days. After that, only 2 or 2½ milligrams per 100 cubic centimeters of blood. This is only one-half the amount of blood concentration which Doctor Forster applied in his 167 cases and which he kept at a level of 5 milligrams per 100 cubic centimeters from twenty to forty days.

In summarizing, these authors are of the opinion that, in spite of subjective improvement of the patient, recovery from trachoma is "not the rule but the exception."

Another article which was most unfavorable to sulfanilamide was the one by Doctor Spinning, who used this drug on thirty-two Navajo Indians. About one-half of them had an unspecific conjunctivitis or phlyctenular conjunctivitis which overlapped the trachoma. The others showed various degrees of scarring. He reported only one clinical cure among the thirty-two.

Before we evaluate these contradictory reports, I would like to remind you that, for convenience, the evolution of trachoma has been divided by MacCallam, and, many years before that, by Fuchs, into four stages:

Stage 1: The early stage of infiltration and discharge.

Stage 2: The period of active inflammation with formations of follicles until scar tissue begins to appear. This may last some years.

Stage 3: The stage of scarring.

Stage 4: When healing has been effected and no further inflammatory activity is evident.

Dr. Harry Gradle, who is well known to every one of you, wrote a letter to the editor of the *American Journal of Ophthalmology* on April 18, 1940, in which he passes judgment on the article of Doctor Spinning, and more or less evaluates all the reports of the effects of sulfanilamide on trachoma in a nutshell: "I wish to protest against the condemnation of the drug. This protest is based upon the experiences that my colleagues in the Indian Service, in the trachoma clinics of southern Illinois, the Illinois Eye and Ear Infirmary and I have had with sulfanilamide—not with the mere handful reported, but with nearly sixty times that number, observed and followed for a period of over two years.

"Despite the popular concept of its magical properties, sulfanilamide cannot eliminate scar tissue and the resultant deformities of the later stages of trachoma. Only death can do that. The older the trachoma, the later become manifest the beneficial result of sulfanilamide therapy. In fact, in many cases from three to six months are required before follicles will disappear. In trachoma, Stages 1 and 2, the drug is 100 per cent effective in the eradication of the disease, provided the patient does not develop manifestations of systemic toxication. In trachoma, Stage 3, during the formation of the scars, from 60 to 70 per cent results can be obtained, depending upon the amount of scar tissue present. In trachoma, Stage 4, no results need to be expected."

It seems to be the irony of fate that it was not Lindner who did a great deal of research work on trachoma, nor Noguchi in Japan, who spent a lifetime searching for a cause and treatment of trachoma, but unknown doctors—Doctor Heineman in Dutch East India and Doctor Loe of the Indian Service in this country—who found an effective remedy against this so widely spread scourge, which shows that it is not always the logically thinking research man who reaches the final goal, but often a man who had the right intuition, or brain wave, as you might call it. Both of these men had really no logical reason to expect anything from sulfanilamide in trachoma. Nevertheless, the credit is theirs.

AUTHOR'S EXPERIENCE

Since I have told you what medical literature tells us about the value of sulfanilamide in trachoma, I should like to tell you my own first experience with the drug.

REPORT OF CASE

In June, 1938, before we were told about sulfanilamide, I had a patient with trachoma under my treatment. His eyes belonged to the third stage of trachoma, which showed still marked hyperemia and infiltration of the conjunctivae, also pannus and corneal scars which often broke down. At that time, it was the end of two long years during which I treated this man, who had had the trachoma for three years altogether. He came to my office two or three times a week. I treated him in the usual way, with the copper stick, quinin bisulphate ointment, and about every six months I rolled his lids with Knapp's forceps. At the end of my two years' treatment the man was no better off than when he came to me the first time. He was terribly discouraged. He was tired of living, because he could not get a job with his droopy, watery eyes. On June 16, 1938, I went on a vacation and told the man to see Doctor Irvine in my absence. Doctors A. Ray and Rodman Irvine attended the American Medical Association convention in San Francisco, where Doctor Loe told us about the remarkable effect of sulfanilamide in the treatment of trachoma. Immediately after their return to Los Angeles, they got in touch with my patient. They put him on more than adequate doses of sulfanilamide. The patient became deathly sick. During my absence, while my secretary was in the office, he used to stop in to see her, after he had seen Doctor Irvine, and cry on her shoulder. She told me, when I came back, she had never seen a man "look as sick and green," as she put it, as our patient. He wondered if he should keep on with Doctor Irvine, as he was actually frightened from the effect of sulfanilamide. My secretary gave him encouragement and told him that he might just as well give it a chance, as nobody had succeeded in doing anything for him. So he did stick it out. Three days after the treatment was instituted, the photophobia disappeared, also the secretion. When I came back to Los Angeles on July 14, the only notation I made on my record was, "Most remarkable improvement I ever saw."

OTHER DISEASES

Other ocular conditions where sulfanilamide is of great value are infected foreign bodies, especially when they produce hypopyon. Several such cases were reported. Sulfanilamide should be used also in orbital cellulitis or abscesses around the lids.

Not so long ago I had a man who had an abscess just below his right eyebrow, nasally, above his tear sac, with a beginning erysipelas around it. I put him on sulfanilamide. In addition, I incised the abscess the usual way. The man was well in four days.

Most men do not get striking results with sulfanilamide or its derivative in recurrent stys.

Dr. Kenneth Swan reported good results with sulfanilamide in three cases of pseudo-membranous conjunctivitis. Corneal ulcers seem to be benefited. Kleefeld treated twenty cases of herpes of the cornea and five of drendritic ulcers. All of them were cured. How much faster they were cured than if sulfanilamide had not been used, is hard to say.

The use of sulfanilamide caused clinical improvement in a case of sympathetic ophthalmia, which was later proved by autopsy.

TABLE 1.—*Regarding the Use of Sulphanilamide and Its Derivatives in Ophthalmology*

Sulphanilamide Prontosil Neoprontosil	Sulfathiazole	Sulfapyridine
Primarily for trachoma, and	Primarily for gonococcus infections, and	Koch-Weeks infections
Betahemolytic streptococcus infections	staphylococcus infections	Meningococcus infections
Koch-Weeks infections	B. Coli infections	Pneumococcus infections
	Infections of unknown etiology, also for	
	Prophylactic	

Sulfanilamide is also used locally. There is a rather recent article written by Doctor Guyton of the Wilmer Ophthalmological Institute, who is not enthusiastic about the results either in ordinary conjunctivitis or in trachoma. He used a 5 per cent sulfanilamide ointment. The only encouraging results he had were in infected corneal ulcers.

Another fact which should be mentioned in a paper which deals with the relation of sulfanilamide to the eye is that once in a great while patients who take sulfanilamide for one reason or another develop a temporary myopia which is probably due to a temporary swelling of the lens. One man, Bucy, reported optic neuritis due to sulfanilamide. I do not believe that report was confirmed by anybody else.

IN CONCLUSION

The most pronounced effects of sulfanilamide have appeared in patients where streptococci or gonococci have been identified in or around the eye. The drug is invaluable during the first two and even third stage of trachoma.

Before ending, I wish to say that trachoma is the most widely spread eye disease. We do not realize it here in this country because there is not much trachoma here, except among the Indians. On the other hand, if we stop to think that in northern Africa, in densely populated India, where hundreds of million people live, in China, where four hundred million people live, and in Russia where there are nearly two hundred million people—considering that in all these countries, trachoma alone or trachoma, combined with gonorrheal ophthalmia, is the most widely spread serious eye disease, then we shall be able to appreciate the full value of this discovery for the prevention of blindness.

727 West Seventh Street.

CLINICAL NOTES AND CASE REPORTS

ULCERATIVE STOMATITIS AND SKIN RASH DUE TO SULFAPYRIDINE

REPORT OF CASE

J. FRANK DOUGHTY, M. D.
Tracy

MR. B. B., age twenty-six, was seen on June 1, 1940, complaining of a sore throat, headache, and photophobia, of one day's duration.

Examination showed redness of the conjunctiva, and a faint macular rash of the chest and back. There were ulcerated discrete papules over the roof of the mouth, cheeks, and gums, which gradually increased in size until almost the whole buccal mucosa was ulcerated, and lips cracked. The mucosa appeared somewhat like mucous patches of syphilis. The rest of the physical examination was not remarkable. The patient's temperature was 102; and pulse, 100. A slight cyanosis was present.

Apparently this was an atypical case of measles, with less rash and more involvement of the buccal mucosa. However, further questioning revealed the fact that the patient had been under treatment for urethritis and had been taking some pills which had been prescribed for him. A check-up of the prescription showed that it was for sulfapyridine; and the directions: one tablet every four hours. Each tablet contained .5 gram of sulfapyridine, and the patient had been taking this drug from May 3, 1940, to June 1, 1940, during which time no blood counts had been done, and no smears made. Total tablets taken, 112; total grams, 56 (grains, 862.4).

The first blood count showed 3,870,000 red blood cells, and 8,700 leukocytes. Daily blood counts showed an increase in the red blood cells, and gradual return to normal in the leukocyte count. At no time was there any abnormal urinary finding.

On June 2, 1940, there appeared on the prepucial mucosa several small ulcerated discrete papules, which appeared similar to those in the mouth. The blood Wassermann was negative.

COMMENT

Treatment consisted in the immediate discontinuance of the sulfapyridine; the stimulation of elimination; the administration of nicotinic acid; and tomato juice for vitamin C. The ulcerated lesions of the buccal mucosa were treated by having the patient wash his mouth frequently with cod-liver oil. This not only stimulated rapid healing of the lesions, but relieved the soreness of the mouth and throat remarkably.

All lesions of the mucous membrane were healed by June 15, 1940, and the patient had no complaint

other than weakness at this time. Physical examination was negative, except for a slight pigmentation at the site of the skin lesions, and evidence of loss of weight.

A similar case was reported, due to sulfapyridine, in which there was a "pseudomembranous" coating of the buccal mucosa, but without ulceration.[1]

231 West Eleventh Street.

HIPPOCRATES' APHORISMS*

Moses Scholtz, M. D.
Arcadia

Section Six (Continued)

24. If a small intestine
Is once cut,
It can't regrow
Into a solid gut.

25. It augurs ill, if outward spreading
Erysipelas turns within;
But a move in the opposite direction
Helps recovery to win.

26. If in acute fevers
Chills do come,
They're carried off
By delirium.

27. If pus or dropsy in the pleura
Is cured by cautery or knife,
And the fluid pours out all at once,
The sick will lose his fight for life.

28. Eunuchs do not
Contract the gout,
Nor do their hairs
Tend to fall out.

29. Women do not
Take the gout,
Unless their menses
Are staying out.

30. Young men are not
Subject to gout,
Unless they revel
Many nights out.

31. Pains of the eyes can be relieved
By taking baths, by fomentation,
By drinking of pure wine,
Or venesection and purgation.

32. In those whose speech
Becomes impeded,
The cure is by
Loose bowels speeded.

33. The sick with acid
Eructations
Don't tend to pleura
Inflammations.

34. The bald-headed sick are not inclined
To form enlargements of the veins,
And should their veins become enlarged,
Their glabrous scalp its hair regains.

35. A spell of hiccups
In the course of dropsy
Leads to an early
Necropsy.

36. Bleeding from
The brachial vein
Is a cure
For bladder pain.

37. If, in a case of quinsy, swelling
Goes to the surface of the neck,
It augurs well, as the outward spread
Drives sickness out from its track.

38. With deep cancer left untreated,
The sick much longer last;
But, if it is tampered with
They fail and perish fast.

39. Hiccups and convulsions
Are caused by the fruition
Of two noxious extremes—
Repletion and depletion.

40. When pain without inflammation
Sets in about the stomach-pit,
A supervening fever
Suppresses it.

41. If the body-part in which pus gathers
Does not point and does not yield,
This strong resistance to pus presence
Comes from the denser tissue build.

42. If in a case of jaundice
A liver starts to indurate,
It is a direful omen
Of a coming fatal state.

43. If patients having enlarged spleens
Develop chronic dysentery,
And then are seized with dropsy, enteritis,
They are on their way to a mortuary.

44. Ileus joint with strangury
In seven days is apt to kill,
Unless brought out by fever heat,
Copious urine shall distill.

45. When ulcers stay unhealed a year
Or more, the bones then, too,
Share in disease and slough away,
And sunken scars ensue.

46. The sick who get
Hunch-backed from cough
Or asthma before puberty
Are soon carried off.

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1 Moore, Mary L., and Forbes, R. P.: Pneumococcal Meningitis with Report of Sulfapyridine Reaction Involving Mucous Membranes, J. Pediat., 16: 347 (March), 1940.

* For other aphorisms, see California and Western Medicine, March 1940, page 125; April 1940, page 179; May 1940, page 231; July 1940, page 35; August 1940, page 85; September 1940, page 130; December 1940, page 272; January 1941, page 27; February 1941, page 82; March 1941, page 124; April 1941, page 229; July 1941, page 35; September 1941, page 140.

47. When bleeding or purging
Are needed, the spring
Is the most proper
Time for the thing.

48. Dysentery, joint
With enlargement of the spleen,
Often helps the sick
His health to win.

49. The inflammation
In a case of gout
Subsides before
Forty days are out.

50. When severe wounds
Strike the brain,
Bile-spit and fever
Sweep the terrain.

51. If persons in good health are seized
With headache, stricken speechless,
And breathe with stertor, in seven days
They die, unless high fever breaks the stress.

52. If a portion of the white comes through
Between the closed eyelids in sight,
(Sans diarrhea or strong purge),
The sick shall lose his final fight.

53. Deliriums with laughter
Are less with danger fraught
Than those with somber mood,
When patients are distraught.

54. In acute
And fevered illness,
Moaning, breathing
Bodes distress.

55. Gouty troubles
For the most part
In spring and fall
Flare up and start.

56. Melancholic humors
Are apt to cause
Total apoplexy, fits,
Blindness, mental flaws.

57. The prey of
Apoplectic strokes
Are mostly
Middle-aged folks.

58. Omentum bulging
Through a wound
Turns to gangrene
And sloughs around.

59. If in chronic troubles of the hip
The bone protrudes and then slips back
Into its socket, it indicates
That there is mucus in the sack.

60. If in a chronic trouble of the hip
The bone's protruding from its joint,
The limb gets crippled and paralyzed,
Unless the part be cauterized.

Section Seven

1. Cold extremities,
In illness acute,
Are deservedly
Of ill repute.

2. Livid flesh,
In a diseased bone,
As an evil omen
Should be known.

3. When vomiting is joint
With hiccups and red eyes,
The sickness takes ill turn;
The patient fails and dies.

4. A chill following
Perspiration,
Is unlucky
Indication.

5. Dysentery, dropsy
Or mania, which appear
During mental sickness,
Portend good cheer.

6. In a protracted sickness
Loss of appetite and loose
Intestinal discharges,
To bad sequelae conduce.

7. Rigor and delirium,
That come from heavy drinking,
Are harbingers of evil days:
They bode the tippler's sinking.

8. The rupture of
Internal abscess
Brings vomiting, collapse
And loss of consciousness.

9. Delirium and fits,
That follow a bleeding,
Forecast much prolonged
Invaliding.

10. If vomiting, convulsions,
Or hiccup and delirium
In ileus occur,
More dangers are to come.

11. Pneumonia, engrafted
On pleurisy,
Betrays of the disease
A dangerous tendency.

12. Pneumonia, in combination
With inflammation of the brain,
Is an evil omen, indicating
That the healer's effort is in vain.

13. Tetanus or fits,
After a heavy burn,
Are a sign that the disease
Takes an evil turn.

413 Longden Avenue.

(To be continued)

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L. G. Hunnicutt, Pasadena.
George W. Walker, Fresno.

General Medicine:
Russel V. Lee, Palo Alto.
George H. Houck, Los Angeles.
Mast Wolfson, Monterey.

General Surgery (including Orthopedics):
Frederick C. Bost, San Francisco.
Clarence J. Berne, Los Angeles.
Sumner Everingham, Oakland.

Industrial Medicine and Surgery:
Richard O. Schofield, Sacramento.
Delos Packard Thurber, Los Angeles.

Plastic Surgery:
George W. Pierce, San Francisco.
William S. Kiskadden, Los Angeles.

Neuropsychiatry:
John B. Doyle, Los Angeles.
Olga Bridgman, San Francisco.

Obstetrics and Gynecology:
Erle Henriksen, Los Angeles.
Daniel G. Morton, San Francisco.

Pediatrics:
William A. Reilly, San Francisco.
William W. Belford, San Diego.

Pathology and Bacteriology:
David A. Wood, San Francisco.
R. J. Pickard, San Diego.

Radiology:
R. R. Newell, San Francisco.
Henry J. Ullmann, Santa Barbara.

Urology:
Lewis Michelson, San Francisco.
Albert J. Scholl, Los Angeles.

Pharmacology:
Chauncey D. Leake, San Francisco.
Clinton H. Thienes, Los Angeles.

† For complete roster of officers, see advertisIng pages 2, 4, and 6.

INDEX

1. *Committee on Medical Preparedness, on page 206.*
2. *Committee on Public Policy and Legislation, on page 208.*
3. *Committee on Public Health Education, on page 208.*
4. *Committee on Postgraduate Activities, on page 211.*
5. *California Medical Association Cancer Commission, on page 213.*
6. *County Societies, on page 214.*
7. *Woman's Auxiliary, on page 216.*
8. *California Physicians' Service, on page 217.*

CALIFORNIA COMMITTEE ON MEDICAL PREPAREDNESS†

Medical Supplies and Priorities

Since the advent of priorities as a part of the current national defense picture, many physicians and medical institutions have been concerned about the possible shutting off of medical and surgical supplies because of prior demands of defense industries recognized by the Office of Production Management. Fears of such material stoppages have been expressed particularly for surgical and diagnostic instruments, which require steel and alloys, and for x-ray equipment, which uses steel, copper, bakelite, and roentgen tubes.

Physicians may now rest assured that their essential materials will continue to be supplied by manufacturers, defense material priorities notwithstanding.

A letter, in response to a California Medical Association request to the Office of Production Management, outlines the manner in which materials on the Office of Production Management's "Health Supplies List" will continue to be furnished to manufacturers for fabricating and distribution to the medical profession. The Office of Production Management has set up a Health Supplies Section, which has power to issue priority ratings classified by the Office of Production Management as A–10.

Basically, the health supplies program of the Office of Production Management permits producers of items on the official list to secure raw materials needed in their manufacture under a priority rating of A–10, which is made a part of the complete Office of Production Management's priority plan. Materials on the Health Supplies List are the following:

1. Adhesive plasters
2. Anesthesia apparatus and supplies
3. Biologicals, antitoxins, and serums
4. Clinical thermometers
5. Diagnostic instruments

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the chairman of the California Committee on Medical Preparedness. Charles A. Dukes, M. D., 426 Seventeenth Street, Oakland, is a member of the American Medical Association Committee on Medical Preparedness. Roster of county chairmen on Medical Preparedness appeared in CALIFORNIA AND WESTERN MEDICINE, August, 1940, on page 86.

6. Hospital laboratory equipment and supplies
7. Hospital operating-room equipment
8. Hypodermic syringes and needles
9. Instruments (surgical and dental)
10. Medicinal chemicals (limited to medical use only)
11. Rubber hospital sundries
12. Sterilizers, hospital
13. Surgical dressings
14. X-ray equipment and supplies (medical and dental).

Any physician who is told by a supplier that specified materials cannot be delivered because of inability to secure a raw material priority should immediately tell that supplier that there is an Office of Production Management plan by which the supplier can obtain an A–10 priority for such articles as are listed above. In case there is further delay on the ground of priorities, please send all facts to the California Medical Association central office, where every effort will be made to secure expeditious delivery of contemplated purchases.

* * *

Military Surgeons' Meeting

Among the many medical meetings of this year, one of the most timely and interesting is that of the Association of Military Surgeons of the United States to be held on October 29 to November 1 at the Brown Hotel, Louisville, Kentucky.

All members of the medical profession are invited to attend as guests, and it is particularly hoped that as many members of the Medical Defense Committees as possible will come.

War medicine and surgery has changed considerably since the previous emergency. Mechanization of armies and air bombardments have created new and difficult problems in traumatic surgery and methods of treatments of wounds and extreme abrasions.

The session concludes with a mass review of Military Medicine and an inspection of Fort Knox.

* * *

Emergency Medical Service for Civilian Defense

The first of a series of pamphlets outlining medical provisions for civilian defense, designed for the organization of emergency medical field units, entitled *Emergency Medical Service for Civilian Defense,* Bulleting No. 1, has been issued by the Office of Civilian Defense.

The Bulletin outlines in considerable detail a basic plan for the organization and expansion of hospital facilities along both seaboards and in industrial areas in the interior. It also outlines plans for the rapid expansion of nursing facilities through intensive training of adequate numbers of volunteer nurses' aides and other nursing auxiliaries. . . .

The pamphlet describes the changed technique of warfare predicated upon the bombing of civilians as necessitating preparation for providing medical service to casualties through establishment of medical field units. It declares the organization of such facilities must be a fundamental part of the civilian defense program.

After outlining, in diagram form, the structure of Emergency Medical Service, the pamphlet thereupon describes in detail the basic organization plan. . . .

The Bulletin was prepared by the Medical Division of the Office of Civilian Defense, of which Dr. George Baehr, Medical Director, United States Public Health Service, is Chief Medical Officer, and the Medical Advisory Board, of which he is chairman. It will be distributed by State Councils of Civilian Defense to local Directors of Civilian Defense. The office of the Ninth Civilian Defense Area is located at 233 Sansome Street, San Francisco.

* * *

United States Public Health Service: Training Courses for Nurses

Surgeon-General Thomas Parran of the United States Public Health Service recently called for fifty thousand well-educated young women to begin training this fall for professional nursing careers in order to "avert serious damage to the nation's health during the present emergency."

Doctor Parran declared that this large number of students is needed to meet the tremendous demand for graduate registered nurses as a result of the national defense program. Student nurses actually contribute valuable service shortly after entering schools of nursing, and thus would relieve more staff nurses in civilian hospitals to assume defense duties, he pointed out.

The States Relations Division of the United States Public Health Service, under Doctor Parran's direction, is administering a recent Congressional appropriation of $1,250,000 which will facilitate the training of these additional nurses. . . .

In addition to recruiting more student nurses, thousands of registered graduate nurses are being mobilized for total national defense.

The American Red Cross is conducting an enrollment campaign for its First Reserve, official reservoir of nurses for the Army and Navy, and at present has an enrollment of 20,549. . . .

Surgeon-General James C. Magee of the Army reports that "the Army Nurse Corps is enrolling approximately 600 reserve nurses per month. At present there are 5,831 nurses on active duty, of which 4,512 are reserve nurses. The authorized quota for the Army Nurse Corps for the fiscal year of 1942 is 8,237 nurses. This is expected to be achieved by December 31.

"Should the country declare war at any time in the future, the need for more registered graduate nurses would mount astronomically. This is based on records of the last war, when nearly 22,000 nurses were on active duty."

The Navy Nurse Corps, while necessarily smaller than the Army nursing staff, is also expanding. . . .

Among other Government nursing agencies planning expansions in their personnel is the Veterans' Administration, which now employs approximately five thousand registered graduate nurses. . . .

Civilian hospitals in some parts of the country are understood to be critically affected by the increasing demand for nursing service. At present, there are approximately ten thousand vacancies in all graduate registered nurse positions in the nation's hospitals, according to a recent survey published in the *American Journal of Nursing.* . . .

A nation-wide recruitment campaign has just been launched to enroll the required additional thousands of high school and college graduates in schools of nursing for the fall term, which begins next month. Young women with good educational backgrounds who are interested in becoming professional nurses are being urged to contact the superintendents of nurses in their local hospitals, or to write to the Nursing Information Bureau at 1790 Broadway, New York City, for full details on the training program.

* * *

Ninth Civil Defense Area

(COPY)

OFFICE OF CIVILIAN DEFENSE
WASHINGTON, D. C.

September 22, 1941.

To Secretary of California Medical Association:

On September 13, 1941, Mayor LaGuardia sent the following telegram in connection with the appointment of Dr. Wallace Hunt to the Ninth Civilian Defense Area:

"Dr. Wallace Hunt, 2451 Westmont Way, Seattle, Washington, commissioned today Senior Surgeon, United States Public Health Service, for duty as Regional Medical Officer, Ninth Civilian Defense Area. Hunt being instructed establish contact Washington State Defense Council before proceeding San Francisco.

You are at liberty to publish the above paragraph in the journal of your State organization.

Very truly yours,
(Signed) GEORGE BAEHR, M. D.,
Chief Medical Officer.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION†

Osteopathic Interns in Army Hospitals

No further action has been taken on H. R. 4476, relative to osteopathic interns in Army hospitals. It is still pending in the Senate Committee on Military Affairs.

Chiropractors and the United States Employees' Compensation Act

As reported in Federal Legislative Bulletin—1, Representative Tolan of California introduced on January 3 a bill, H. R. 1052, to permit chiropractors to treat beneficiaries of the United States Employees' Compensation Act. The bill is identical with a bill introduced by the same Congressman in the Seventy-sixth Congress, H. R. 8963, on which hearings were held but no further action taken.

The pending bill was referred to the House Committee on the Judiciary and by it referred to a subcommittee composed of the following members: Charles F. McLaughlin, Nebraska; Sam Hobbs, Alabama; Dave E. Satterfield, Jr., Virginia; Thomas H. Eliot, Massachusetts; Clarence E. Hancock, New York; Raymond S. Springer, Indiana; and Joseph P. O'Hara, Minnesota.

The foregoing subcommittee is not the same one that gave consideration to the similar bill during the Seventy-sixth Congress, but information has been received that the present subcommittee will not hold public hearings on H. R. 1052. Its recommendation will be based on the hearing held last year. It is understood, however, that the subcommittee will welcome any statements that interested persons may desire to file.

Dr. Henry H. Kessler, a member of the American Medical Association Council on Industrial Health, appeared at the hearing last year as a witness to present the viewpoint of the Association. He has filed an additional statement this year, reëmphasizing the reasons he presented last year to justify the position that the enactment of the bill would be in the interest neither of injured federal employees nor of the advancement of scientific medicine. Doctor Kessler has offered the following additional suggestion to the subcommittee:

"Frankness compels me to suggest that the Congress acted unwisely in 1938 when it amended the same section of the United States Employees' Compensation Act as it is now proposed further to amend, by singling out osteopaths for special favors. It was then pointed out that such recognition would precipitate demands by adherents of other forms of sectarian medicine. That prophecy, of course, has materialized in the form of the pending bill embodying the demands of the chiropractors. In the printed hearings on H. R. 8963 you will find on page 38 reference to demands on the part of the naturopaths for similar favors.

Other forms of sectarian healing are recognized in one or more of the several States, such as neuropathy, napropathy, magnetic healing, mechanotherapy, psychotherapy, spondylotherapy, and faith healing. And if we may judge the future in the light of the past, the end may not yet be in view. The policy that the Congress adopted in 1938, referred to in the preceding paragraph, constitutes an open invitation to all of these various groups to present their demands to Congress for favors similar to those accorded the osteopaths. Cannot these various groups logically contend: "If you place the stamp of federal approval on one group of sectarian healers, without any investigation whatsoever as to the scientific basis of the theories underlying the practice of that group, can you in justice withhold similar favors from other groups?" There can be, it seems to me, but one forthright answer to that question.

If the Congress desires to act in the interest of the injured federal employees for the benefit of whom the United States Employees' Compensation Act was passed, and not primarily in the interest of any group of practitioners, it should seriously review, in connection with the pending bill, the action it took in 1938 and by proper amendment delete from the act reference to any form of sectarian medicine. If under a general authorization to provide the necessary care and treatment for injured federal employees covered by the act the administrative agency, the United States Employees' Compensation Commission, cannot be relied on to provide competent practitioners to supply that care and treatment, then the remedy must be sought elsewhere than in the provisions of the 1938 amendment or in the provisions of the pending bill.

On August 19, Senator Murdock of Utah, for himself and Senator Gillette of Iowa, introduced a companion bill in the Senate, S. 1861. This bill was referred to the Senate Committee on the Judiciary, of which Senator Van Nuys of Indiana is chairman. Senator Murdock was a member of the House of Representatives during the Seventy-sixth Congress and was a member of the subcommittee of the House Committee on the Judiciary that gave a public hearing on H. R. 8963, referred to previously.

† Component County Societies and California Medical Association members should not give endorsements to proposed legislation unless the California Medical Association Committee on Public Policy and Legislation has so requested. On such matters, address: California Medical Association Committee on Legislation, Dwight Murray, M. D., Chairman, 450 Sutter, San Francisco. Telephone, DOuglas 0062.

COMMITTEE ON PUBLIC HEALTH EDUCATION†

Los Angeles County Fair

Thousands of Pieces of Literature on Many Health Subjects, Prepared for Lay Reading, Presented From the Booth of the Los Angeles County Medical Association

The picture on the opposite page tells the story of the first exhibit of the Los Angeles County Medical Association at the Los Angeles County Fair at Pomona.

Those members of the Association who stopped at the booth during those times of the day when the crowds were heaviest know the value of this exhibit to medicine; they have seen the interest shown by the people in authentic health information.

While the booth was but one of many in the vast space reserved for educational displays under the grandstand, it apparently stood out above all others in point of interest. In the early hours of the forenoon—at the time the picture on the opposite page was taken—it attracted the attention of practically everyone who was in the space under the grandstand. At times, forty and fifty men and women were waiting in line to obtain the literature that was offered.

More than two thousand persons stopped at the booth during each day of the Fair. Nearly every one of these asked for one or more pieces of literature. If the literature they wanted was not available, their names and addresses were taken; the literature to be sent to them at a later date.

The feature that attracted the visitors to the booth was a full-length x-ray picture showing the entire body from the hairpins in the lady's hair to the nails in her high-heeled shoes. Once they had stopped at the booth, the display of educational literature caught their attention. They did not pick up this literature just because it was free. Nearly every one of them made a close study of the vari-

† The Committee on Public Health Education was established through Substitute Resolution No. 6 at the Del Monte annual session, May 3, 1939.

The Committee on Public Health Education consists of Frank R. Makinson, chairman, Oakland; Philip K. Gilman, secretary, San Francisco; Samuel Ayres, Jr., Los Angeles; Thomas A. Card, Riverside; James F. Doughty, Tracy; Lowell S. Goin, Los Angeles; Junius B. Harris, Sacramento; Henry S. Rogers (ex officio), Petaluma. Communications to the committee may be addressed to Frank R. Makinson, M. D., chairman, Wakefield Building, Oakland, or to the California Medical Association office, 450 Sutter Street, San Francisco.

Fig. 1 (*top left*).—Portion of the exhibit of the Los Angeles County Medical Association displayed at the Los Angeles County Fair held at Pomona, Friday, September 12, to Sunday, September 28, inclusive. There was a large placard with legend, "Health Defense, Los Angeles County Medical Association," centered above the main exhibit. A life-size x-ray exhibit was the special feature to attract persons. The small diorama showing physician at bedside of sick child was placed to left of exhibit. The battery of charts on the wall above were from *Hygeia*.

Fig. 2 (*top right*).—Extension portion of the Los Angeles County Medical Association exhibit. Framed charts were loaned by the Los Angeles County Heart Association.

Fig. 3 (*center left*).—Booth of the Los Angeles County Health Department. Exhibits featured nutrition studies. Special legends stated:

"High Officials Tell Us: Proper Nutrition Is One of Our Chief Defense Problems." "Old 'Doc' says: 'You Can't Stay Well If You Don't Eat Right.'" "Look! The three trays below will help you plan the use of *balanced diet menus* for today." "Take a set of the leaflets in the rack below and you will find balanced diet menus for every day in the week."

Fig. 4 (*center right*).—Another portion of the booth of the Los Angeles County Health Department. On the five sectors of the pentagon circle were displayed the following: milk products; vegetables; cereals; meats and eggs; other groceries.

Fig. 5 (*bottom left*).—Portion of the tuberculosis booth. A major legend: "Tuberculosis Costs You Money. Find It—Treat It—Save Money." This booth contained two quiz racks with cards asking "What Do You Know About Tuberculosis?" Each quiz rack had a shelf upon which the cards and card punches were placed. Visitors used the punches and then dropped their cards in the proper slits.

Fig. 6 (*bottom right*).—Exhibit of Works Progress Administration.

California Fairs—Tentative Dates for 1941

The following is a list of County Fairs held in 1941, with dates. Population of counties is also given.

Serial No.	Dates Held	County (Name)	Place Held	Fair Secretaries	Population
1	Mar. 1- 9	Imperial County Mid-Winter Fair	Imperial	D. V. Stewart	70,000
2	13-23	National Orange Show	San Bernardino	William Starke	134,000
3	May 16-18	Solano County Fair	Dixon	M. E. Morgan	41,000
4	16-18	Calaveras County Fair	Angels Camp	Joseph Rydberg	6,000
5	22-25	Butte District Fair	Chico	Mrs. Sylvia Cooke	34,000
6	30-June 1	Mariposa County Fair	Mariposa	George W. Robinson	3,000
7	June 12-14	Tehama County Fair	Red Bluff	Jens C. Petersen	14,000
8	20-22	Placer District Fair	Auburn	Ray Carlisle	24,000
9	July 3-12	Alameda County Fair	Pleasanton	Ernest Schween	475,000
10	4- 6	Silverado Fair and Horse Show	Calistoga, Napa County	Frank Piner	23,000
11	17-20	Napa County Fair	Napa	Harrison Cutler	23,000
12	23-27	Santa Barbara County Fair	Santa Maria	J. H. Chambers	65,000
14	30-Aug. 3	Sacramento County Fair	Galt	E. Kenefick	142,000
16	Aug. 2- 9	Sonoma County Fair	Santa Rosa	Ralph H. Brown	62,000
17	8-10	Placer County Fair	Roseville	H. A. Crockard	24,000
18	8-10	Contra Costa County Fair	Antioch	Alden Sutton	78,000
19	11-16	Stanislaus District Fair	Turlock	Dr. A. J. Ronsse	56,000
20	12-17	Humboldt County Fair	Ferndale	Dr. J. N. D. Hindley	43,000
21	14-17	Plumas County Fair	Quincy	W. P. Cowan	8,000
22	16-24	San Joaquin County Fair	Stockton	E. G. Vollmann	103,000
23	21-24	Nevada County Fair	Grass Valley	Loyle Freeman	10,000
24	21-24	Butte County Fair	Gridley	W. W. Tull	34,000
25	22-24	Mendocino District Fair	Ukiah	Norman G. Buhn	23,000
26	23-24	Trinity County Fair	Hayfork	J. D. Rourke	3,000
27	19-Sept. 7	*California State Fair*	Sacramento	Kenneth R. Hammaker	
30	Sept. 4- 7	Modoc County Fair	Cedarville	J. Ray Golden	8,000
31	11-13	Shasta District Fair	Anderson	Dudley Saeltzer	13,000
32	11-14	Monterey County Fair	Monterey	V. V. Adams	54,000
33	12-14	El Dorado County Fair	Placerville	John Winkelman	8,000
34	12-14	Amador County Fair	Plymouth	Mrs. Goula Wait	8,000
35	12-28	Los Angeles County Fair	Pomona	C. B. Afflerbaugh	2,208,000
36	16-20	Glenn County Fair	Orland	J. J. Flaherty	11,000
37	17-21	Del Norte County Fair	Crescent City	C. A. Cronkhite	5,000
38	18-21	Sutter-Yuba Counties Fair	Marysville	J. A. Fredericks	25,000
39	18-21	San Mateo County Fiesta	San Mateo	Chester Lipman	77,000
40	19-21	Tuolumne County Fair and Horse Show	Sonora	Mrs. Francis Graham	9,000
41	19-21	Yolo County Fair	Woodland	Harry Crego	23,000
42	22-27	Tulare-Kings Counties Fair	Tulare	A. J. Elliott	102,000
43	24-28	Humboldt District Fair	Eureka	Randolph Smith	43,000
44	24-28	Merced County Fair	Merced	J. J. Uhle	36,000
45	25-28	Colusa County Festival	Colusa	Daniel E. Weyand	10,000
46	30-Oct. 5	Fresno District Fair	Fresno	T. A. Dodge	144,000
47	Oct. 4-12	San Diego County Fair	Del Mar	D. A. Noble	209,000
48	4-12	Santa Clara County Fair	San Jose	Russell Pettit	145,000
49	8-12	Ventura County Fair	Ventura	John Lagomarsino	55,000
50	9-12	Madera County Fair	Madera	H. J. Bunce	17,000
51	10-12	San Benito County Fair	Hollister	J. M. Leonard	11,000
52	16-19	Santa Cruz County Fair	Watsonville	M. W. Johnson	37,000

ous pieces before them and selected those which appealed to them and then asked if there were any charge for it.

The Committee on Public Policy and Relations, in planning for this exhibit, made a careful study of the literature offered by the American Medical Association as a part of their public relations and educational program, and then, with information gained from the experiences of others at fairs of this kind, ordered a large quantity of this material from the American Medical Association, believing that they had ordered enough to last through the eighteen days of the Fair.

However, the Association booth proved far more attractive than anyone had anticipated, and the many cartons of literature which were taken to the Fair by truck disappeared within the first four days. A rush order to the American Medical Association was put through for further literature. This last order, according to Dr. W. W. Bauer, Director of the Bureau of Health Education of the American Medical Association, cleaned out their supply.

Usually one finds literature of this type is picked up and then thrown away. However, little, if any, of this literature was found discarded. It was saved for home reading, and those who got it spoke to others about it, because many came to the booth and asked for certain pamphlets which friends of theirs had told them they could receive at our display.

This illustrates how effective this public relations activity has proved to be. Certainly it warrants exhibits at future fairs.

Much credit goes to the Committee on Public Policy and Relations of the Los Angeles County Medical Association: Dr. Paul A. Quaintance (chairman), Dr. Arthur E. Smith, and Dr. Wallace Dodge.

In the opposite column are listed the various pamphlets and booklets distributed at the booth. Thousands of each of these were well accepteed.

THIS LITERATURE IN DEMAND

Following are the titles of the various pamphlets and booklets which were received by thousands at the Los Angeles County Fair at Pomona last month:

Some Contributions by Animals to Human Health (excellent bit of literature answering arguments of anti-vivisectionists). [Note:—This leaflet was printed by the Committee on Public Health Education of the California Medical Association.]
The Truth About Cataracts
Athlete's Foot
Acne: The Plague of Youth
A Woman Faces Fifty
If I Keep My Health
The Common Cold
Safeguarding the Takeoff to School
Keeping Your Baby Well
What Science Knows About Cancer
Our Food and Our Teeth
How to Choose a Doctor
Watch Your Diet
How to Be an Intelligent Patient
Those First Sex Questions
Story of Life
In Training
How Life Goes On
Experimentation and Animals
That Annual Check-Up
Exercise, an American Fetish
Reducing Diets
How to Gain Weight
Ups and Downs of Weight

Any of the above items may be obtained from the American Medical Association for your reception room.*

* For editorial comment concerning County Fairs, see page 169.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Lane Medical Lectures

The twenty-eighth course of Lane Medical Lectures will be delivered by Cecil K. Drinker, M. D., D. Sc., Professor of Physiology and Dean of the School of Public Health, Harvard University, on the evenings of October 6, 10, 13, 17, and 20, 1941, at 8:15 o'clock in Lane Hall, Stanford University School of Medicine, at Sacramento Street near Webster, San Francisco.

The medical profession, students, teachers, and research workers in medicine and allied sciences are cordially invited to attend.

1941 LANE LECTURES

THE LYMPHATIC SYSTEM

Physiological and Clinical Considerations
by Cecil K. Drinker, M. D., D. Sc.

Lecture I

October 6—Physiological Principles Displayed in the Evolution of the Mammalian Circulation.

Lecture II

October 10—The Blood Capillaries of Mammals.

Lecture III

October 13—The Appearance and Elaboration of the Lymphatic Vessels.

Lecture IV

October 17—The Blood, the Tissue Fluid, and the Lymph as Illustrated by Certain Experiments Upon the Heart and Other Organs.

Lecture V

October 20—Some Lessons for Medicine and Surgery.

* * *

University of California Medical School

Refresher Course: "Clinical Aspects of New Therapy"

The University of California Medical School will offer a refresher course, "Clinical Aspects of New Therapy," in Toland Hall, University of California Hospital, San Francisco, January 5, 6, and 7, 1942.

The course, which will be intensive and designed to meet the needs of physicians in practice, will include the following subjects: Sulfonamide Drugs; Drugs Used on Central Nervous System; Organotherapy; and Drugs Used in Treatment of Diseases of the Adrenal Gland; New Drugs Acting on the Heart and Circulation and Clinical Aspects of Nutrition.

Members of the faculty will participate. Complete and detailed programs will be available shortly. These will be obtainable, upon request, at the Dean's office of the Medical School.

* * *

Southern California Chapter of the American College of Surgeons

Inaugural meeting, held at Los Angeles, October 9–10, 1941. Program follows:

GENERAL SURGERY

Section I

Thursday, October 9, 9:30 a. m., California Hospital

Panel Discussion

Surgery of the Upper Abdomen

Chairman, E. C. Moore

Cholelithiasis—Carl A. Bachuber.
Biliary Tract Disease—O. Dale Lloyd.
Diseases of the Pancreas—Isaac Y. Olch.
Hematemesis—Lewis A. Alesen.
Gastroscopy—Harold Lincoln Thompson.
Peptic Ulcer—J. Norton Nichols.

* * *

Friday, October 10, 9:30 a. m., California Hospital

Panel Discussion

Carcinoma of the Breast

Chairman, Maurice Kahn

Statistics—Ian McDonald.
Diagnosis—William S. Quinn.
Surgical Treatment—Harry K. Bonn.
Diagnosis and Pathology—John W. Budd.
Radiology—Clyde K. Emery.

* * *

GENERAL SURGERY

Section II

Thursday, October 9, 9:30 a. m.

Cedars of Lebanon Hospital

Panel Discussion

Diseases of the Thyroid

Chairman, Clarence G. Toland

Anatomical Studies of the Neck—C. J. Baumgartner.
Preparation of the Difficult Patient—Marcus H. Rabwin.
Substernal Goiter—Ralph V. Byrne.
Carcinoma of the Thyroid—William P. Kroger.
Exophthalmic Goiter—E. L. Turner.

* * *

Friday, October 10, 9:30 a. m.

Cedars of Lebanon Hospital

Panel Discussion

The Large Bowel

Chairman, Charles T. Sturgeon

X-ray Diagnosis of the Diseases of the Colon—Kenneth S. Davis.
Miller Abbott Tube—L. C. Bennett.
Diverticulitis—Solomon Strouse.
Total Colectomy for Ulcerative Colitis—Max W. Bay.
Carcinoma of the Colon—E. Eric Larson.

* * *

Obstetrics and Gynecology

Thursday, October 9, 9:30 a. m.
Hollywood Hospital

Panel Discussion

Chairman, E. J. Krahulik

Hormone-Producing Tumors of the Ovary: Presentation of representative cases, including theca cell tumor, granulosa cell tumor, arrhenoblastoma, and adrenal cell tumor—correlation and discussion of clinical and pathological material.

Erle Henrikson — L. Grant Baldwin
Roy E. Fallas — A. N. Webb

Postpartal Morbidity: The time-worn yardstick for estimating morbidity (temperature above 100.4) is considered inadequate. The following titles have practical significance.

Lacerations—Norman H. Williams.
Infections—Ralph Thompson.
Lassitude—Raymond McBurney.
Backache—A. M. McCarthy.
Constipation and Urinary Disturbances—John C. Irwin.

Friday, October 10, 9:30 a. m., Hollywood Hospital

Panel Discussion

Chairman, Harold K. Marshall

Prolonged Labor—
As It Is Affected by Architecture of Pelvis—A. M. McCausland.
Presentation and Position of the Fetus—William B. Thompson.
Soft Parts (Cervix and Lower Uterine Segment)—John Vruwink.
Uterine Inertia—B. J. Hanley.
Analgesia—Joseph M. Harris.

Reconstructive Pelvic Surgery for Genital Prolapse—
An evaluation of principles and methods
Ventral Fixation
Watkins Interposition
Vaginal Subtotal Hysterectomy with Interposition of the Cervical Stump
Manchester-Fothergill
Vaginal Hysterectomy
Le Fort Colpocleisis

Speakers: Henry N. Shaw, Rafe C. Chaffin, William H. Brownfield, George E. Judd, and John C. McDermott.

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

Section on Orthopedic and Traumatic Surgery

Thursday, October 9, 9:30 a. m.

Los Angeles County Medical Building

Length of Papers and Discussions: The time allowed for the presentation of a paper shall be limited to fifteen minutes. Each discussion will be limited to five minutes.

Panel Discussion

Chairman, Hugh Toland Jones

The Care of the Acutely Injured—

Factors in Mortality as Seen in the Coroner's Office—Louis J. Gogol. Discussion opened by Roy Hammack.

The Management of Shock—Robert J. Moes. Discussion opened by Wallace Dodge and Ralph Ferguson.

Brain and Spinal Cord Injuries—C. Hunter Shelden. Discussion opened by Dorrell Dickerson and George Patterson.

The Management of Chest Injuries—Lyman A. Brewer. Discussion opened by Frank Dolly and Hans E. Schiffbauer.

The Traumatic Abdomen—Anton Laubersheimer. Discussion opened by Harlan Shoemaker and Edward C. Pallette.

The Treatment of Compound Injuries of the Extremities—Francis McKeever. Discussion opened by John Wilson.

Friday, October 10, 9:30 a. m.

Orthopedic Hospital

Chairman, Charles S. Young

Rigid Internal Fixation and Primary Closure of Compound Fractures of the Tibia—Walter Scott. Discussion opened by John Dunlop and Vernon Thompson.

Fractures of the Elbow in Children—Ward M. Rolland. Discussion opened by William Arthur Clark.

Treatment in Various Disabilities of the Knee Joint—Hugh T. Jones. Discussion opened by Charles S. Young.

The Neurological Aspects of Pain in the Arm and Shoulder—C. Hunter Shelden. Discussion opened by Carl Rand and Carl Von Hagen.

Dupuytren's Contracture of the Palmar Fascia, with Particular Attention to Etiology and Pathology, John K. Black. Discussion opened by J. E. Kahler and William S. Kiskadden.

Interscapular Fascial Transplants in Poliomyelitis—Charles L. Lowman. Discussion opened by Robert L. Carroll.

* * *

Urology

Thursday, October 9, 9:30 a. m.

Los Angeles County Hospital

Management of Vesical Neck Obstructions:

Chairman, Paul A. Ferrie,

Collaborators: Samuel K. Bacon, Donald Charnock, and Charles Monte Stewart.

Endoscopic Prostatic Surgery—Benign Hyperplasia—Roger W. Barnes.

Other Bladder-Neck Pathology and History—Clyde W. Col ings.

Friday, October 10, 9:30 a. m.

Los Angeles County Hospital

Malignancies of the Kidney and Ureter:

Chairman, Harry W. Martin

Collaborators: A. A. Kutzmann and E. E. Kessler.

Malignancy of the Urinary Bladder and Testicle:

Chairman, Jay J. Crane

Collaborators: H. A. Rosenkranz, Lyle G. Craig, and Frederick A. Bennetts.

* * *

Eye, Ear, Nose, and Throat

Thursday, October 9, 9:30 a. m.

Children's Hospital

Eye Clinic—Ray Irvine and Staff.

Ear, Nose, and Throat Clinic—J. Mackenzie Brown and Staff.

Friday, October 10, 9:30 a. m.

Los Angeles County Hospital

Ear, Nose, and Throat Clinic—J. Hackenzie Brown and Staff.

Eye Clinic—William A. Boyce, Ray Irvine and Staff.

* * *

Proctology

Thursday, October 9, 9:30 a. m.

Hospital of the Good Samaritan

Chairman, W. H. Kiger

Surgical Significance of Some Points of Anal Anatomy—P. C. Blaisdell.

Significance of Distant Symptoms Due to Anorectal Pathology—A. J. Murrieta.

Motion Picture Photography of the Rectum and Rectosigmoid—David Miller.

Surgical Versus Injection Treatment of Internal Hemorrhoids—D. N. Yaker.

Pruritus Ani—Malcolm R. Hill.

Friday, October 10, 9:30 a. m.

Hospital of the Good Samaritan

Chairman, A. J. Murrieta

Differential Diagnosis of Anorectal Pathology—F. G. Re Bell.

Pre- and Postoperative Care of Anorectal Surgery—C. M. Taylor.

Diagnosis and Treatment of Abscesses and Fistulae of the Anorectal Region—M. I. Lomas.

Tumors of the Lower Colon—W. H. Daniel.

* * *

General Meetings

Los Angeles County Medical Association Building

1925 Wilshire Boulevard

Thursday, October 9, 2 p. m.

Chairman, Frank J. Breslin

Surgical Aspects of the Use and Abuse of the Sulfonamides:

Pharmacological Considerations—Lester H. Lonergan, Associate Professor of Pharmacology and Therapeutics, College of Medical Evangelists, Loma Linda.

Obstetrics and Gynecology—Gail Fehrensen.

Neurosurgery—R. B. Raney.

Ophthalmology—Rodman Irvine.

Urology—Jay J. Crane.

Orthopedic Surgery—Donald T. Babcock.

Otolaryngology—Charles E. Futch.

Proctology—Malcolm R. Hill.

Thursday, October 9, 3:30 p. m.

Surgical Aspects of the Use and Abuse of the Barbiturates:

Pharmacological Considerations—

In addition, Arthur E. Guedel will represent the anesthetists.

Friday, October 10, 2 p. m.

Chairman, William H. Brownfield

Vitamins in Surgery—Clinton H. Thienes, Professor of Pharmacology, University of Southern California.

Water Balance in Surgery—Howard F. West and Lewis F. Ellmore.

Minerals in Surgery—Burrell O. Raulston, Professor of Medicine, University of Southern California, and Clarence J. Berne.

Iodine Metabolism—E. J. Jorgensen.

* * *

Dinner Meeting

Los Angeles County Medical Association Building
1925 Wilshire Boulevard, Los Angeles

Friday, October 10, 6:30 p. m.

The American College of Surgeons and Its Objectives—Donald G. Tollefson.

Control of Surgery in the Private Hospital—Walter A. Bayley.

Educational Requirements of the Surgeon—Verne C. Hunt.

* * *

Postgraduate Clinics on Heart Disease

San Francisco Heart Committee: Twelfth Annual Three-Day Postgraduate Symposium on Heart Disease, October 30, 31, and November 1.

Dr. Paul Dudley White, guest speaker. Clinics to be held at University of California, Stanford and San Francisco Hospitals by Doctor White and members of the San Francisco Heart Committee. Fee, $15. Open to all physicians. Dr. Francis L. Chamberlain, Program Chairman, Room 407, 277 Pine Street, San Francisco.

Los Angeles Heart Association Postgraduate Symposium on Heart Disease, November 4 and 5.

All day and evening sessions. Dr. Paul Dudley White, guest speaker. Open to all physicians. Fee, $5. Dr. Lewis T. Bullock, Program Chairman, 1136 West Sixth Street, Los Angeles.

* * *

San Diego Heart Committee Symposium, November 3 or 6.

Dr. Paul Dudley White, guest speaker. Dr. James F. Churchill, Chairman, Medico-Dental Building, San Diego. Please write to Doctor Churchill for registration and fee.

* * *

Ninth Annual Symposium on Heart Disease

LOS ANGELES HEART ASSOCIATION, LOS ANGELES

NOVEMBER 4 AND 5, 1941

PROGRAM

Tuesday Morning Session, November 4

Los Angeles County Hospital, Room 1436, 10 a. m.

A Cardiac Clinic

Discussion of the Diagnosis and Treatment of Four Cases of Heart Disease—Paul D. White.

* * *

Tuesday Afternoon Session, November 4

County Medical Association Building, 1925 Wilshire Boulevard, 2 p. m.

The Present Status of the Therapy of Bacterial Endocarditis—E. Richmond Ware.

Recent Advances in the Treatment of Thrombophlebitis—Clarence J. Berne.

Temporal Arteritis—A. M. Roberts.

Differential Diagnosis of Syncope—Maynard Brandsma.

An Evaluation of the Therapy of Hyperactive Carotid Sinus—Russell W. Lyster.

* * *

Dinner Meeting, Tuesday, November 4

1925 Wilshire Boulevard, 6:30 p. m.

Heart Failure—Paul D. White.

* * *

Wednesday Morning Session, November 5

1925 Wilshire Boulevard, 10 a. m.

Digitalis Intoxication, an Increasingly Frequent Cause of Death—William Paul Thompson.

Recent Contributions to the Pathology of Coronary Thrombosis—Richard D. Evans.

Current Theories of the Mechanism and Treatment of Hypertension—Burrell O. Raulston.

The Diagnostic Significance of Relative Aortic Insufficiency—Marvin B. Corlette.

The History and Interpretation of the First Heart Sound—William Nance Anderson.

* * *

Wednesday Afternoon Session, November 5

1925 Wilshire Boulevard, 2 p. m.

The Present Indications for the Use of Digilanid C.—William D. Evans.

The Place of Vital Capacity Determinations in Cardiac Diagnosis—Coleman Hendricks.

The Value of Venous Pressure Determinations—Thomas H. Brem.

The Practical Use of Circulation Time Tests—Horace B. Cates.

Contributions of the Past Year to Electrocardiography—William H. Leake.

Exercise and Anoxemia Tests in the Diagnosis of Angina Pectoris and Other Forms of Coronary Insufficiency—Francis M. Smith.

* * *

An Exhibit

In the Library, Throughout Symposium

Historical contributions to our knowledge of heart disease. Prepared by William Nance Anderson.

A Film

In the Library, Tuesday and Wednesday, 1:30 p. m. Wednesday, 12 noon

"The Circulation of the Blood," as demonstrated by William Harvey.

A motion picture prepared by Sir Thomas Lewis. Loaned by Elmer Belt.

* * *

Registration fee, $5. Includes: Symposium; the dinner; a year's subscription to *Modern Concepts of Heart Disease*; yearly dues to Los Angeles and California Heart Association.

Mail reservation requests to Lewis T. Bullock, Secretary, 1136 West Sixth Street, Los Angeles.

* * *

San Diego Postgraduate Conference, October 28-30—Preliminary Announcement

On Tuesday, Wednesday, and Thursday, October 28-30, at 7:30 p. m., the San Diego County Medical Society will sponsor a clinical conference on gastro-enterology.

The meetings will be held in the Mercy Hospital, Hillcrest Drive, near Fifth and Washington streets.

Members of the San Diego, Orange, Riverside, San Bernardino, and Imperial county medical societies are invited to participate.

Dr. John C. Ruddock of Los Angeles, on Tuesday, has on his list of topics the following: Ascitis; Palpable Liver; Alcoholism; Ascitis in Women; Vague Upper Abdominal Pains; and Latent Jaundice.

Dr. Eric Larson of Los Angeles, on Wednesday, will take up: Duodenal Ulcer; X-ray Diagnosis of Cancer of Stomach; Women with Gastric Distress and Pelvic Tumor; Pelvic Exploratory or Abdominal Adhesions with Vomiting and Distress; Esophageal Hernia.

Dr. William C. Boeck of Los Angeles, on Thursday, will discuss: Acute Peptic Ulcer; Chronic Gastritis; Spastic Colitis; Chronic Appendix.

C.M.A. CANCER COMMISSION†

California Medical Association Cancer Commission: Pathology Conference

The semi-annual Microscopic Pathology Conference of the Cancer Commission will be held in the Science Building of the University of Southern California, University Avenue and Thirty-sixth Street Place, Los Angeles, on Sunday, December 14, 1941, at 9:30 a. m. As in the past, any individual wishing to present a case should send a sample slide and case history to the chairman of the committee for examination as soon as possible.

The committee arranging the meeting consists of Dr. Roy Hammack (chairman), Dr. Ernest Hall, and Dr. Newton Evans.

If the case is accepted for presentation, the committee will notify you so that you may make sixty slides and case histories for distribution. These sets should be sent to Dr. Otto H. Pflueger, in care of California Medical Association, 450 Sutter Street, San Francisco, so that they may be distributed to the participants prior to the meeting. In order that this may be done, all material should be received by the undersigned by November 30 at the very latest. Material coming in later than that cannot be sent out.

Kindly send your preliminary history and slide to the chairman of the committee, Dr. Roy Hammack, 657 South Westlake Avenue, Los Augeles. Please make reservations for the conference through Dr. Otto H. Pflueger, 384 Post Street, San Francisco.

† For roster of members of the Cancer Commission of the California Medical Association, see page 2 in the front advertising section (bottom of the second column).

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (57)

Alameda County (3)

James R. Armstrong, *Oakland*
Arthur J. Hunnicutt, *Oakland*
John M. Simpkin, *San Leandro*

Los Angeles County (48)

William H. Bachrach, *Los Angeles*
Edison Pierce Bacon, *Santa Monica*
Nathan J. Barlow, *Bell*
Glenn L. Barnum, *Pasadena*
Geneva K. Beatty, *Long Beach*
Thomas H. Brem, *Los Angeles*
Lyman A. Brewer, *Los Angeles*
Royal Elis Brisbane, *Long Beach*
Harold D. Covell, *Los Angeles*
Wilfred Louis Deleray, *Rosemead*
Connelly M. Dobson, *Los Angeles*
John J. Durkin, *Los Angeles*
John O. Eiler, *Long Beach*
Bertrand L. Ellis, *Glendale*
George Fein, *Beverly Hills*
Irwin Globerson, *Santa Monica*
Morris Goldenberg, *Los Angeles*
Lawrence H. Hall, *South Pasadena*
Ralph Hanna, *Los Angeles*
Robert Hare, *Beverly Hills*
Reginald R. Herren, *Los Angeles*
Vernon Arthur Ingle, *Montebello*
J. Warren Johnson, *Los Angeles*
Ralph H. Kelson, *Inglewood*
Alfred Lewis, *Los Angeles*
Cecil J. Lord, *Los Angeles*
Edward G. Mack, *Beverly Hills*
William A. Macpherson, *Huntington Park*
Julian B. Marks, *Los Angeles*
Neil P. McCloy, *Los Angeles*
I. Lew Mintz, *Los Angeles*
Wendell A. Morgan, *Monterey Park*
John J. Morreale, *Los Angeles*
John A. Murphy, *Alhambra*
Earl F. Nation, *Los Angeles*
George A. Nicola, *Los Angeles*
John Orobko, *Los Angeles*
Siebert C. Pearson, *Santa Monica*
Samuel Perrie, *Long Beach*
Wilmot F. Pierce, *Los Angeles*
Robert B. Portis, *Los Angeles*
Maurice John Regan, *Los Angeles*
Robert G. Shirley, *Beverly Hills*
Willard S. Small, *Pasadena*
Floyd Winfield Smith, *Alhambra*
Frederick K. Sutterlin, *Bell*
John Ovenstone Westwater, *Los Angeles*
Theodore William Witalis, *Pomona*

San Francisco County (5)

Siegfried Fischer, *San Francisco*
Verne T. Inman, *San Francisco*
Emil Lowy, *San Francisco*
Clarence Nelson, *San Francisco*
Harold Sugarman, *San Francisco*

Santa Barbara County (1)

Allen H. Williams, *Santa Barbara*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

Transfers (4)

Ray C. Atkinson, from Placer-Nevada-Sierra County to Alameda County.

Gerald L. Crenshaw, from Merced County to Alameda County.

Seymour Dudley, from Ventura County to Los Angeles County.

Virgil E. Hepp, from Yuba-Sutter-Colusa County to San Francisco County.

In Memoriam

Bittner, Simon Peter. Died at Glendale, August 30, 1941, age 62. Graduate of University of Oregon Medical School, Portland, 1906. Licensed in California in 1917. Doctor Bittner was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Green, Aaron Samuel. Died at White Springs, Virginia, September 9, 1941, age 62. Graduate of Denver and Gross College of Medicine, Denver, 1908. Licensed in California in 1909. Doctor Green was a member of the San Francisco County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Grosse, Alfred B. Died at San Francisco, May 29, 1941, age 68. Graduate of Cooper Medical College, San Francisco, 1894. Licensed in California in 1894. Doctor Grosse was a member of the San Francisco County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

McCoskey, Grace. Died at Stockton, August 14, 1941, age 57. Graduate of Stanford University School of Medicine, 1914. Licensed in California in 1917. Doctor McCoskey was a member of the San Joaquin County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Morris, Charles Alfred. Died at Bakersfield. September 8, 1941, age 69. Graduate of College of Physicians and Surgeons of San Francisco, 1902. Licensed in California in 1902. Doctor Morris was a member of the Kern County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Rebec, William George. Died at San Mateo, September 10, 1941, age 45. Graduate of University of Michigan Medical School, Ann Arbor, 1925. Licensed in California in 1931. Doctor Rebec was a member of the San Mateo County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

OBITUARY

George Cooper Pardee
1857–1941

A career of public service lasting more than a half century ended with the death of Dr. George C. Pardee on September 1, 1941.

The former Governor of California and former Mayor of Oakland died at his home at 672 Eleventh Street, Oakland, where he had lived since he was a boy. He was 84.

Doctor Pardee served the public from 1889, when he became a member of the Oakland Board of Health, until May of this year (1941), when he retired as president of the East Bay Municipal Utility District and as director of the Oakland Port Commission.

Doctor Pardee was born in San Francisco on July 25, 1857, the son of Dr. E. H. Pardee, who was also a physician, born in New York, and who studied at Ann Arbor, Michigan, arriving in California in 1849, specializing in diseases of the eye, being probably the first of California's eye specialists. It is stated that "patients came to him from all parts of the Pacific Coast, he seeing frequently 80 to 140 patients a day in his office, half of whom at times were treated gratuitously."

After graduating from Oakland High School, the young George Cooper Pardee studied at the University of California and received his bachelor's degree in 1879. He attended Cooper Medical College in San Francisco and the University of Leipzig and was awarded his medical degree at the German institution in 1885.

Doctor Pardee confined his practice to diseases of eye, ear, nose, and throat. Collegiate degrees received included: Ph.B., University of California, 1879; A.M., 1882; M.D., University of Leipsic, 1885; LL.D., University of California, 1932. He was a member of the Alameda County Medical Society and California Medical Association over many years.

He became a member of the Oakland Board of Health in 1889 and served for two years in that post. Then he was on the Oakland City Council from 1891 to 1893, and was Mayor of the city from 1893 to 1895.

As a regent of the University of California, Doctor Pardee continued public service from 1899 to 1903, in which year he was elected Governor of the State. His four years of service in the governorship included the San Francisco fire of 1906, when his measures for public safety and relief won him national acclaim.

In all the years since he left the state's highest office, Doctor Pardee continued his leadership in public affairs. He was a member of the National Conservation Commission from 1907 to 1909, chairman of the Conservation Commission of the state in 1911 to 1915, and chairman of the State Forestry Commission in 1919 to 1923, and 1928 to 1930.

He was elected a director of the East Bay Municipal Utility District in 1924 and immediately became its president, an office he held until illness led him to resign in May, last. Most of the growth of the utility district came under Doctor Pardee's presidency, the district having been formed only a year before his election as director.

Doctor Pardee became a member of the Oakland Board of Port Commissioners in 1927, when the Board was formed, and continued in that post until his resignation in May. A resolution adopted by the Board when he resigned noted that he had "given wisely of his counsel and fully of his energy to the port's development in its formative period."

The utility district directors similarly lauded Doctor Pardee on his resignation as their president. They noted that he took office with the district "at a time when most men would have retired from active pursuits and when he neared the proverbial age of three score and ten."

During all of the years that Doctor Pardee served the community as a member of the Port Commission and a member of the board of directors of the East Bay Municipal Utility District, he did so without compensation. It was a part of his public service to the community.

Besides holding the utility district and Port Commission posts, Doctor Pardee also served the state and the nation while he was in his 70's. He was chairman of the California Joint Federal-State Water Resources Commission in 1930.

Doctor Pardee was a delegate to the Republican national conventions in 1900, 1904, 1912, and 1924, and a delegate to the Progressive National Convention in 1912. He was a presidential elector in 1912 and 1924.

The Oakland *Post-Enquirer*, July 24, 1937, on the occasion of the eightieth birthday of Dr. George C. Pardee, under the caption "A Great Record of Public Service," made the following editorial comment concerning the civic services that had been rendered by Doctor Pardee:

Oakland Greets Its Most Distinguished Citizen

"George C. Pardee, ex-governor of California and president of our municipal utility district, will observe his eightieth birthday tomorrow (July 25, 1937). His home city of Oakland, and all of California, will congratulate him and his family. He has reached the eighty-year mark still vitally alert to the public interest he has served so long and still serves so indispensably. This is probably more a matter for which we should congratulate ourselves, for few cities have benefited more greatly from one man's unselfish contributions of energy and experience to the common welfare.

"With Doctor Pardee, public service is a habit of more than fifty years. He began his long career of good work fifty-two years ago as a young Oakland doctor, recently graduated from the medical school of Leipzig, Germany, and interesting himself in problems of public health. He soon became a member of the city Board of Health, and was later elected to the City Council and then to the office of mayor of Oakland. In the entire half-century since he began his career in Oakland he has served the people of his city, state, or nation continuously in some important capacity, but, with the exception of the four years he served the people of California as governor, he has never drawn a salary for his public work. From 1903 to 1907 he was governor of the state. Before that he was a regent of the University of California. He has served the nation as a member of the National Conservation Committee. For many years he was chairman of the California State Conservation Commission and the State Forestry Commission. Since 1927 he has served as a member of the Oakland Port Commission. He has served as chairman of the Federal and State Water Resources Commission.

"Since 1924 he has been president of the East Bay Municipal Utilities District, directing the destiny of that vast public undertaking, conserving its resources, lowering both district taxes and water rates, paying off indebtedness and creating the sound basis of an enterprise that will pay for itself and give the people of this district a water system free of debt. He has not only given his home community a splendid administration of its most important civic enterprise; he has given the entire nation a model of wise administration of a public ownership project, and that model has been widely followed.

"So today we may be grateful that Oakland's most distinguished and useful citizen, who will be eighty years old tomorrow, is still active in his work. It has been, and still is, a great work.

"This city has been rarely fortunate in possessing as one of its citizens a man endowed both with ability of so high a caliber and such unselfish devotion to the public good. If this good fortune is rare among cities, it is because men of this type are rare. Doctor Pardee, born in California in the days of the gold rush, coming from the stock of pioneers, has fulfilled the highest traditions of the pioneers—he has been a builder, a constructive force in the world, conserving for his fellows and those who will come after him the best of this world's values and resources.

"May he have many more years of active, useful life."

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. HARRY O. HUND.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM.....Asst. Chairman on Publicity

President's Outline of Suggestions to County Auxiliaries and Projects for 1941–1942

1. Study both the State and your County Constitutions, in order to know how the Auxiliary functions.

2. Know the objects of the Auxiliary, as stated in Article II of the State Constitution: "To bring its members into more active affiliation with organized medicine; to encourage kindly social relationships; to coöperate with the California Medical Association and its component county societies and other organizations in all desirable public health and social welfare work."

3. Know the platform of the American Medical Association.

4. Read articles pertaining to Auxiliary work in California and Western Medicine.

Read the *Bulletin* of the Woman's Auxiliary to the American Medical Association.

Study the *Handbook* which is published by the Woman's Auxiliary to the American Medical Association.

Through these a clearer insight will be given of the scope of the work that the Auxiliary is carrying on.

5. *Never* send out any letters in the name of the Auxiliary in regard to policy unless sanctioned by the Advisory Council through the State President.

All work carried on by the Auxiliary must first be approved by the Advisory Council of the California Medical Association.

† Reports of county chairmen of publicity should reach Mrs. Rossner Graham, Assistant Chairman of Publicity, 6101 Acacia, Oakland, by the tenth of the month previous to publication. Address of the Chairman of Publicity: Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

6. Have active coöperation between the State and County officers, also with the district councilors. The members of the State Board stand ready to help in every way that they are able, so do not hesitate to call upon them. The State chairmen have formulated outlines which will be of interest and value to the County chairmen.

7. Strengthen all departments by paying special attention to programs of vital interest to your community.

PROJECTS

1. *To increase membership*, as the greatest influence of the Auxiliary, lies in the personal contacts the individual members have with lay organizations in their own communities. There is a definite need, especially in these changing and difficult times, to have this influence felt.

2. *To Promote Hygeia.* This is a project which the American Medical Association has asked us to sponsor.

3. To aid the work of the Auxiliary Committee for the Medical Benevolence Fund.

4. *Legislation.* To be ready to give full coöperation to the California Medical Association when a call goes out in regard to any legislative matter.

To study the various aspects of legislation which pertain to medicine, in order to be correctly informed when talking to the laity. Promote an educational program in the practical workings of politics. The Woman's Auxiliary to the American Medical Association has prepared for this work a very comprehensive outline.

5. To coöperate with the National President and the National chairmen of standing committees in carrying out the plans of the Woman's Auxiliary.

6. *Public Relations.* Through meetings open to lay organizations, disseminate authentic health information, and promote friendly relations between the public and the medical profession. Plan to promote a health institute or health days.

7. Promote interest in radio programs sponsored by the medical profession.

8. To strive to induce each member to have an annual physical examination.

9. To include in our program this year, subjects pertaining to

Home Defense and Nutrition

(*a*) Problems of food conservation.
(*b*) Adequate diet for the civilian population.
(*c*) Recreational projects.

10. Coöperate with medical defense.

As an Auxiliary to the California Medical Association, we may not affiliate with other organizations; but we should give full support by our individual services to all those carrying on a great humanitarian work.

Our Auxiliary plans must go forward in the spirit of service to humanity.

The Woman's Auxiliary has already been placed in the front ranks of those creating an understanding of authentic health information, and so may it gather greater strength in spite of the difficulties we shall face during the coming year.

Respectfully submitted,

Mrs. Harry O. Hund,
President, Woman's Auxiliary to the California Medical Association.

September 5, 1941.

* * *

News Items

Alameda County Auxiliary activities will start this season with a luncheon meeting at the Claremont Country Club on September 19. *Our Foreign Policy—Is It Changing?* will be discussed by Mrs. Nathaniel Gardner.

Mrs. Abbott Crum, president, will preside. Members will be welcomed by Mrs. Ira Church and Mrs. George Calvin, past presidents.

* * *

Plans for the Opera Tea, which is an annual event of the Woman's Auxiliary to the Sacramento Society for Medical Improvement, are being completed. Proceeds from this benefit, scheduled for Sunday, October 5, will go to the Philanthropic Fund.

* * *

At the beginning of this Auxiliary year, it gives us great pleasure to welcome the Inyo-Mono Auxiliary. For this new unit of our organization and its president, Mrs. H. W. Crook, we wish happiness and success in the coming year.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

September, 1939	1,220
March, 1940	9,322
September, 1940	17,398
March, 1941	24,107
September, 1941	30,071

The Board of Trustees of California Physicians' Service met in San Francisco on Saturday, September 20, 1941. The affairs of California Physicians' Service were subjected to critical analysis. A brief summary of the actions taken at this meeting is as follows:

1. The two-visit deductible contract (in which the patient pays the first two visits himself) will be the only plan offered after October 1, 1941, where full medical coverage is desired. This was done in an effort to put more responsibility for use of service on the beneficiary member.

2. Females cost more than males. Therefore, an increase in rate for females will be put into effect at once on new groups.

3. Family coverage will be added to the surgical benefit plan. This will increase the coverage in the low-income groups, and should take California Physicians' Service into a new field on a sound actuarial basis.

The incidence of illness continues to be too high. For May, June, and July, 1941, it has been 3 to 4 per cent higher than comparable months in 1940. Part of this is due to the appearance of elective surgical procedures (tonsils and hernias) for members who have passed the one-year waiting period. The high percentage (40 per cent) of continued cases which have had treatment in the previous month or months is a matter of concern to California Physicians' Service and medically can only mean that many cases are being treated for chronic conditions.

* * *

Administrative membership terms expire in twenty-one districts in the state in January, 1942. Nominations for professional members to fill these vacancies will be open early in November. The medical profession, generally, should be interested in these nominations, as the members of the Board of Trustees of California Physicians' Service (the policy-making body) are selected from the administrative membership.

* * *

The first issue of the California Physicians' Service monthly report is on file with the secretaries of the local county medical societies. The medical profession should take advantage of the information contained therein. Many favorable comments on this report have been received at the California Physicians' Service office from interested persons in California and throughout the United States. The next issue will be released immediately.

† Address: California Physicians' Service, 333 Pine Street, San Francisco. Telephone EXbrook 3211. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

MEDICAL EPONYM

Gordon's Sign

Alfred Gordon (b. 1869), of Philadelphia, instructor in nervous and mental diseases, Jefferson Medical College, wrote of "A New Reflex: Paradoxic flexor reflex; Its Diagnostic Value" in *American Medicine* (8:971, 1904).

> It has been my good fortune to observe a new reflex which I found present in cases, the history of which points to organic diseases of the nervous system, and especially of its motor tracts; I found it always associated with exaggerated knee-jerks; in some cases the Babinski reflex was present, in some not. . . .
>
> The reflex can be elicited in the following manner:
>
> The patient may either lie on his back or sit on a chair with the feet (not the legs) on a stool. The feet must be slightly rotated externally; in this position complete relaxation of the muscles of the leg is obtained. The examiner must always place himself to the outer side of the leg; the thenar and hypothenar muscles of his right hand must be placed on the inner surface of the tibia of the patient and the fingers pressed deeply upon the middle or the lower portion of the calf muscles. I say deeply because the pressure must be transmitted to the flexor muscles of the deep layer; sometimes pressure must be combined with lateral movements of the superficial muscles. If the reflex is present, extension of the great toe, or of all the toes, will be noticed. There is evidently no other muscle except the flexors that could be brought into display. . . .
>
> If excitation of the flexors produces an extension of the toes, the reflex is certainly paradoxic. . . .—R. W. B. in *New England Journal of Medicine*, February 13, 1941.

An Occupational Fungous Disease.—Prompt diagnosis and treatment are essential in cases of sporotrichosis, an occupational fungous disease, Frank M. Gastineau, M. D.; Louis W. Spolyar, M. D., and Edith Haynes, Ph. D., Indianapolis, point out in *The Journal of the American Medical Association* for September 27 in a report of six cases among florists.

The causative fungus is called Sporotrichum schencki. The disease chiefly affects agricultural manual workers and tends to be disabling and chronic if not diagnosed early. It is generally initiated by an abscess due to injury of the skin, followed by a series of nodules or lumps under the skin which are painless and later ulcerate. The ulcers resemble tuberculosis of the skin, syphilis sores, staphylococcic infections or tularemia, known as rabbit fever. The authors point out that if the disease is not diagnosed early the victim "undergoes an economic loss out of proportion to his disease; he may also suffer a stigma due to a wrong diagnosis."

Discussing the source of their patients' infections the authors say: "Tabulation of the raw materials and by-products used revealed that all six handled different fertilizers, three used peat moss of different brands and all used sphagnum moss, plumosa and flat ferns. One used home-grown carnations and one grew roses. Epidemiologically, the common denominator appeared to be the sphagnum moss, the plumosa or the flat fern. . . ."

We become willing servants to the good by the bonds their virtues lay upon us. Service to man is the highest service to God.—Sidney.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.†

California Medical Association, Hotel Del Monte, Del Monte, California, May 4–7, 1942.

American Medical Association, Atlantic City, June 8–12, 1942.

American Medical Association Meeting of State Medical Association Secretaries and Editors, 535 North Dearborn Street, Chicago, Friday and Saturday, November 21–22, 1941.

Forum on Allergy: Fourth Annual Conference, Detroit, Michigan, January 10–11, 1942.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of federal government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts.*

Los Angeles County Medical Association.

The following is the Los Angeles County Medical Association's radio broadcast schedule for the month of October, 1941.

Saturday, October 4—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, October 4—KFI, 10 a. m., The Road of Health.
Saturday, October 11—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, October 11—KFI, 10 a. m., The Road of Health.
Saturday, October 18—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, October 18—KFI, 10 a. m., The Road of Health.
Saturday, October 25—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, October 25—KFI, 10 a. m., The Road of Health.

New Building for Army Medical Library.—Reference was made in Federal Legislative Bulletin—7 to H. R. 5146, a bill authorizing the acquisition of a site on which to construct a new building for the Army Medical Library. As noted in the previous reference, the bill had passed the House and was pending in the Senate with a favorable committee report from the Senate Committee on Military Affairs. The bill was reached on the Senate calendar on August 11, but consideration of it was postponed because of a conflict that arose over what Senate committee should have had jurisdiction over the bill. On August 14, on motion of the Chairman of the Committee on Public Buildings and Grounds, Senator Maloney of Connecticut, the bill was referred to that committee. Subsequently, on August 21, the bill was again reported to the Senate with a recommendation that it pass. Note: The bill has since gone on to passage.

Plague Control Conference.—Evidence that plague infection among wild rodents of western United States is spreading eastward prompted Surgeon-General Thomas Parran of the United States Public Health Service to call a plague control conference August 28 and 29 at Salt Lake City, Utah.

The conference was attended by health officers from California, Oregon, Washington, Nevada, Montana, Idaho, Wyoming, Utah, Colorado, Arizona, New Mexico, and North Dakota. Infection among wild rodents has progressed steadily during the past five years from the Pacific Coast eastward as far as the Dakotas. The purpose of the conference was the stimulation of rat control programs in urban and rural areas.

In the past, outbreaks of human plague have almost invariably been preceded by marked increase in the disease among animals which harbor the infection. Plague is passed from rodents to humans by infected fleas. According to Surgeon-General Parran, unless prompt and effective control measures are undertaken plague infection among rodents may spread to the more populous areas of the Middle West and East, creating a serious hazard to humans.

Surveys conducted by the Public Health Service in 1935 revealed plague infection among wild rodents in Montana, California, and Oregon. In each succeeding year, including 1941, infection has been demonstrated in ground squirrels, chipmunks, rats, marmots, and other wild rodents in Arizona, California, Idaho, Montana, Nevada, New Mexico, Utah, Washington, and Wyoming.

Infection among rodents has been discovered recently as far east as North Dakota.

The first outbreak of human plague in this country occurred in 1900 in San Francisco. Plague in California reached epidemic proportions in 1907-1908. Since 1900 there have been 502 cases and 315 deaths in this country. Two human cases of plague, both in California, have been reported this year.

† In the front advertising section of *The Journal of the American Medical Association,* various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Hickman Award to Arthur E. Guedel, M. D., of Los Angeles.—The Anesthetic Section of the Los Angeles County Medical Association, on Tuesday evening, October 21, in the headquarters building at 1925 Wilshire Boulevard, Los Angeles, will tender a dinner to Dr. Arthur E. Guedel of Los Angeles, who has been awarded the "Hickman Medal for Research" by the Royal Society of Medicine of London.

The dinner will be followed by presentation of the award and an address by Dr. Chauncey D. Leake, Professor of Pharmacology at the University of California. Dinner reservations may be made through the Los Angeles County Medical Association (Telephone Drexell 7175).

Adulteration of Hamburger and Chopped Meats.—For the past several months, and especially since the price of meats and its products have shown a rising tendency, some of the butcher trades have shown a greater disposition than heretofore to adulterate hamburger or chopped meats with prohibited chemical substances of sulphites, sulphur dioxide, benzoate of soda, and other chemical preservatives not approved by the lawfully designated agencies.

Fraudulent practices also have been indulged in, such as mascerated spleen and lung tissue, as well as other filler viscera discards being added to chopped or hamburger meats to increase its bulk, and the advertised sales prices were so-called "dead give-aways" that the product was not as represented.

In order to check this from a public health as well as a fraud prevention point of view, the Los Angeles City Health Department inaugurated and is carrying on a check-up and investigation of those practices. The results so far have proved quite enlightening to violators against whom the evidence was incontrovertible, and as a result of prosecution complaints being filed against them, were convicted and fined from $100 to $200 in each instance by the courts before which they were arraigned.

It is probably apparent that this practice is not confined to Los Angeles City alone, as the recent session of the State Legislature took cognizance of its apparent statewide existence, when it amended the State Pure Food Laws by adding this, among other sections thereto:

"A food shall be deemed to be adulterated if it be chopped meat or hamburger, or ground meat sold as such, and if it contains any substance other than the striated muscle of cattle to which is added not more than 15 per cent of fat derived from cattle."

Industrial Medicine and Surgery.—Under the auspices of the American Association of Industrial Physicians and Surgeons the American Conference on Industrial Health will hold its second annual meeting on November 5 and 6, 1941, at Chicago Towers, Chicago, Illinois. This organization maintains a public forum for all who are interested in the prevention of disease, injury and disability in industry, and the active supervision and promotion of health in industrial groups.

The opening session will be a symposium on the technical problems of industrial health on the basis that health supervision in industry involves two great principles: (1) The adjustment of the working environment to the employee; and (2) the adjustment of the employee to the working environment, including also the human environment. The technical problems are the result of the application of these principles, and run the whole gamut of public health as applied to industry.

The afternoon session will be a symposium on the economics of industrial health, including: (1) Organization and cost of a health service; and (2) discussion on the value of industrial health service to the employer, the employee, and the public.

The morning of the second day will be given over to a symposium on the social implications of industrial health, discussing how far an industrial health service should go; are hospital and medical care plans related to industrial health service in any practical way; does legislation play a part in this problem; and the evaluation of labor turnover, spoilage, and lack of trained men, together with the experiences of management and the interests of insurance carriers in the medical and social problems presented.

The sessions will close with a schedule of plant medical department inspections by special arrangements with local industries.

Pharmacological Items of Potential Interest to Clinicians.—An informal bulletin from the University of California Department of Pharmacology reports:

1. *From the Far Eastern Front:* Russo-Japanese journals run behind—reports submitted summer of 1939, published last winter, have just been received. G. A. Petrovsky (Bull. Biol. Med. Exp. URSS, 1940) finds chloral, barbital, phenolbarbital, papaverin, relax bile-duct sphincters, while morphin and codein increase bile-duct tone. E. Tezuka (Jap. J. Exp. Med., 18:387, 1940) reports phenol is absorbed by living or dead bacteria in proportion to mass of bacteria. C. Tsai and associates (Chin. J. Physiol., 16:165, 199, 1941) describe anti-hemolytic activity of normal plasma due chiefly to cholesterol and globulin lowered in malaria and other infectious diseases. C. S. Ray, N. N. Sen, and H. N. Das Gupta (Ind. Med. Gaz., 76:203, 1941) recommend 2 per cent emulsion cadmium sulphide in sterile olive oil, one cubic centimeter twice weekly intramuscularly, as a cheap adjunct to collapse therapy in tuberculosis, and safer, better than gold. J. P. Van der Schroeff (Geneesk. Tijdschr. Nederl. Ind., 81:1103, 1941) reports sulfanilamides of no value in mite fever, tick fever, and typhus; recommends coconut oil on legs as prophylactic against mite and tick fever. K. Helms (Med. J. Austral., 28:717, 1941) suggests deficiency of B complex as factor in virulence of poliomyelitis virus.

2. *New Ideas in Anesthesia:* G. A. Emerson (Anesth. Anal., 20:181, 1941) reports on bromin distribution in organs following administration of NaBr, bromural, tribromethanol, tribromacetaldehyd, "brovalol" and "pernoston"; appears that "avertin" deposits plenty bromin in tissues. C. A. Handley and B. E. Abreu (Anesth. Anal., 20:212, 1941) find that benzedrin significantly antagonizes cortical and respiratory depression of morphin. J. C. Krantz et al. (J. Pharmacol. Exp. Therap., 72:233, 1941) report now that cyclopropyl-ethyl-ether is tops as an inflammable inhalation anesthetic liquid. F. L. Luten et al. (Proc. Soc. Exp. Biol. Med., 47:245, 1941) note that "propazone" (5, di-N-propyl-2, 4, oxazolidine-dione) is equal to barbitals and hydantoins as a hypnotic and anticonvulsant (dose, one gram twice daily), and that its sodium salt in 10 per cent solution intravenously (dose, 50 to 100 mgm/Kg) is a powerful anesthetic. And Arthur E. Guedel, M. D., is awarded the Henry Hill Hickman Medal for outstanding contributions to anesthesia, by the Royal Society of Medicine of London.

3. *Summer Items:* E. F. Patton (Calif. West. Med., 55:35, 1941) suggests benzine pledgets to dissolve poison oak or poison ivy resin and to mop it from skin areas affected. G. Emerson finds saturated solution cinnamic acid in 95 per cent alcohol helpful in dermatophytosis.

4. *Mercury Theophylline Diuretics:* W. Evans and T. Paxon (Brit. Heart J., 3:112, 1941) carefully compared diuretic effectiveness of "Neptal" (May & Baker), "Esidrone" (Ciba), "Salyrgan" (Bayer), and "Mersalyl" (British Drug), and value them in order named. They find intravenous administration always gives greater di-

uresis than intramuscular. For edematous bedridden cardiacs they recommend an intravenous administration of "Neptal" or "Esidrone" every third day, preceded by four enteric-coated tablets of 0.5 gram each of ammonium chloride. For ambulatory cases they recommend "Neptal" tablets (0.5 gram) twice weekly.

5. *Odds and Ends:* D. W. Jolly discusses basic principles in new book, "Field Surgery in Total War" (N. Y., 1941). J. E. Ayre (Canad. Med. Assn. J., 44:575, 1941) suggests thiamin as an antagonist to excessive progesterone which may be factor in endocrine imbalance involved in toxemia of pregnancy. K. M. Bowman and E. M. Jellinek offer comprehensive discussion of alcohol addiction and treatment (Quart. J. Stud. Alc., 2:98, 1941). D. E. Green gives excellent summary of *Mechanisms of Biological Oxidations* (Cambridge, 1940). C. H. Waddington does the same for *Organizers and Genes* (Cambridge, 1940). July Physiol. Rev. (Vol. 21, No. 3) carries articles by A. S. Huggett (London) on fetal nutrition, B. Josephson (Stockholm) on bile acid metabolism, and S. Wright on gene physiology.

Diphtheria Immunization.—A report from the Department of Epidemiology of the Los Angeles City Health Department gives the following:

"During 1934-1935 the Los Angeles City Health Department began the use of alum precipitated toxoid in diphtheria immunization. About two thousand children were immunized in schools and well-baby conferences with this immunizing agent. However, abscesses were observed too frequently to justify continued usage. Plain formalinized toxoid was then again accepted as the sole immunizing agent of the City Health Department.

"Continued favorable reports in the literature regarding the further purification of alum toxoid, and the enthusiasm over its use, again led us to resume the use of alum toxoid in November, 1939. The following year we confined its use to public schools, where economy of time is so important. Since no untoward results were brought to our attention, we extended its use to well-baby conferences in September, 1940.

"Frequent and persistent grumbling followed from our physicians. They observed: (1) More reactions, both local and general; (2) persistent nodules, as long as six months and more after immunization; (3) occasional sterile abscesses (6 in 25,000 immunizations). Although the number of abscesses seem relatively few, there may be even others which did not come to our attention.

"A survey of what other city health departments were experiencing relative to the use of alum toxoid was prompted. Accordingly, questionnaires were sent to fifty major city health departments. Forty-six replied as follows: thirty used alum toxoid exclusively; sixteen did not use alum. Of the thirty using alum, thirteen reported abscesses were observed, but the frequency was not indicated and they did not consider that occasional abscesses seriously deterred an immunization program. Of the sixteen who were not using alum toxoid, five had observed abscesses with alum toxoid.

"Although in our recent experience only few abscesses occurred, we feel even such few are deterrents in our immunization program. In addition to these occasional abscesses, we have found that persistent nodules are a source of great worry to mothers. These observations, plus severe reactions, especially in infants and young children who rarely reacted in such manner to plain formalinized toxoid, have influenced us to again resume use of plain toxoid in our immunization program at our well-baby conferences. Our policy will be three injections spaced four weeks apart.

"To simplify matters in the schools, we shall continue with one-dose alum for the coming school year, unless further observations indicate a change in policy."—Lillian Kositza, M. D., Director, Division of Child Hygiene.

Soldier and His Heart.—"The Soldier and His Heart" will be the subject of an evening lecture given October 30 by Dr. Paul Dudley White, President of the American Heart Association, and one of the recognized authorities on heart disease.

Criteria used by draft boards in selecting enlistees are one of Doctor White's major contributions as chairman of the National Research Council's subcommittee on cardiovascular diseases.

Doctor White will discuss the public health phases of heart disease at a dinner meeting to be held on Friday, October 31, at the Crystal Ballroom of the Western Women's Club, according to Dr. Francis L. Chamberlain, Chairman of the Program Committee.

Clinics will be held by Doctor White at the University of California Hospital, Stanford University Hospital, and San Francisco County Hospital.

Doctor White will be presented by the San Francisco Heart Committee at the three-day symposium on heart disease to be held on October 30, 31, and November 1 in San Francisco.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Cyclotron by 1943

Completion Set for University of California Machine

Although difficulty in obtaining the necessary steel has delayed the work three months, the University of California's new cyclotron, which will be at least five times as powerful as any in existence now, will be completed in 1943.

This was announced yesterday at the University as work on the huge atom smasher passed the one-year mark.

Construction thus far, engineers said, includes foundations for the columns of the twenty-four-sided building that will shelter the apparatus, completion of its thirty-foot magnet except for the top pole piece, and a start on a power transmission line from the campus to the cyclotron site on a hill half a mile away.

The University's present cyclotron weighs 225 tons, while the one now being built will weigh 4,900 tons. It is expected to open new doors in science's search for a solution of the problem of atomic power.—San Francisco *Examiner*, September 12.

* * *

State Census Gain Reported

Sacramento, September 8 (AP).—California's population was estimated at 7,448,418, which is 8.4 per cent more than the 1940 Federal census, by the State Department of Motor Vehicles today on the basis of automobile registrations.

The department attributed much of the estimated increase to the influx of defense project workers from other states.

A total of 348,160 out-of-state automobiles entered California during the first seven months of the year—26.1 and 43 per cent more than in the corresponding periods of 1940 and 1939, respectively. The department expressed belief most of the visitors were seeking work in defense areas.—Los Angeles *Times*, September 9.

* * *

Excessive Speed Is Banned as Limit Is Raised

State Officials Say Little Leeway Will Be Given in 55-Mile Maximum

California's automobile speed limit will be increased to fifty-five miles an hour on Saturday, the effective date of motor vehicle act revisions adopted at the last session of the legislature.

In this connection, James M. Carter, director of motor vehicles, and E. R. Cato, chief of the California Highway Patrol, issued a warning that this will mean no increase in the speed at which most drivers have been permitted for years to drive on the open highways.

Their statement said little tolerance will be allowed above the new maximum. . . .

Doctors May Drive Faster

Physicians responding to emergency calls may disregard speed regulations if they exhibit the insignia of a licensed physician on their cars. This does not relieve them from driving with due regard for the safety of others or protect them from any arbitrary exercise of the privileges so conferred. . . .

Physicians and public health officers must report all cases of epilepsy to the Division of Drivers' Licenses so that a check may be made of their driving records.

License Symbol Authorized

The Department of Motor Vehicles is given authority to renew the registration of vehicles annually without the necessity of issuing new license plates and in lieu thereof to issue a symbol or other device to be fastened to the old plates. This authority is now being exercised to provide "cover plates" for 1942.

When a motorist loses one or both of his plates, an entirely new duplicate set may be issued to him for $1.00 instead of the old fee of $2.

The department will have authority to make a charge of 10 cents for each request for information from its files concerning any vehicle. Exemptions are provided for all public officials engaged in crime investigations and for all information relating to traffic accidents, offenses, or enforcement.

When a man sells his car to another, he is released from liability for negligence when the sale has been completed and the car delivered.—Fresno *Bee*, September 10.

* * *

New York Educators Stress Movies

Board Will Extend Visual Instruction Plan to All Schools

New York, September 7 (Chicago Tribune Press Service). Emphasizing their recognition of the value of visual instruction methods, the New York City Board of Education now is preparing to extend this service so that by February every elementary and junior high school in the city will be equipped with at least one silent motion-picture projector, one stereopticon, and one beaded screen for picture projection. . . .

Most of the schools already have collections of lantern slides to cover completely one school subject in geography, history, or nature study.

In addition, the Bureau of Visual Instruction has distributed twenty-six sound motion-picture projectors and 218 reels of sound motion-picture films, she said. These films are correlated to geography, nature study, primary reading and science courses.—Los Angeles *Times*, September 8.

* * *

Court Postpones Hearing Against Postal Officials

La Verne Mental Healer Brings Action to Force Postmasters to Deliver Letters Addressed by Him

Hearing on an order to show cause obtained by Attorney George Acret of Los Angeles against Postmaster A. E. Harwood of La Verne and Postmaster Mary Briggs of Los Angeles to compel delivery of letters addressed by him to his client, W. H. Neher, La Verne mental healer, was continued yesterday to October 13.

The continuance was asked by Assistant United States Attorney John Marvin Dean to obtain further instructions from the Attorney-General. It was granted by United States Judge Leon R. Yankwich.

Cosmic Generator

Acret charges that two letters sent by him to Neher, containing confidential information "of client and attorney" in a case involving a postoffice order, were returned to him on the claim that "Neher is not entitled to receive mail solely for the reason that a so-called fraud order has been made against Neher." The order resulted from investigation of a cosmic generator machine which Neher asserts is beneficial to health.

In an attack on the fifty-year-old postal statute under which the Neher order was made, Acret charges the measure is "unconstitutional and vicious" and asserts it permits a government agency "upon evidence satisfactory to itself" to deprive "the public of free speech."

Power of Congress

"If Congress can grant the Postoffice Department or other administrative agency power to deny the use of the mails, then Congress can exercise indirectly a censorship upon people and the press which might completely deprive us of our liberties," Acret charged.—Los Angeles *Times*, September 10.

* * *

Funds Given State N. Y. A.

Grant of $3,718,918, with More Anticipated, Allocated for Students

A total of $3,718,918 has been allocated to the National Youth Administration in California for the current fiscal year, which embraces the 1941-42 school year, and another appropriation of several millions is expected in six months, it was learned yesterday from State N. Y. A. Administrator Robert Wayne Burns. The Administration in this State expended $6,671,088 last fiscal year, which ended June 30.

The bulk of the appropriation, $2,347,671 for six months, is to aid the out-of-school young people. It is to be spent mostly in training youth for defense work. The total allocated for this phase of N. Y. A. work last year was $5,018,500. . . .

Needy Students

Burns estimated that the in-school work will aid an average of 20,000 needy students a month in about eighty-eight colleges and universities and 535 secondary schools.

These students do various work for from $10 to $20 a month for college and university students, a few to get from $20 to $30; and from $3 to $6 a month for high school students.

Eligibility Told

School authorities select the needy students to be aided at public expense. The defense trainees are selected by the Administration and State Employment Service. They come "from the lower-income brackets."

Persons eligible for N. Y. A. aid must be between sixteen and twenty-four years of age and must be citizens.—Los Angeles *Times*, September 9.

* * *

Mail Medicine Case Is in Trial

A federal jury today continued hearing testimony in the case of C. A. Isbell and Mr. and Mrs. Fred Mandeville of Colfax, Placer County, who are charged with using the mails to advertise a cure for cancer and other diseases.

Prominent physicians and specialists have been summoned by the Government to refute the curative claims Isbell made for a compound which he offered for sale throughout the United States.

Dr. Alson Kilgore of San Francisco, a specialist in cancer research, testified that medical science is not looking for a drug to cure cancer and that treatment of the disease is limited very much to the use of radium and the x-ray. He also said there is no known drug cure for diabetes, another ailment which Isbell claimed his compound would cure.

Doctors Are Called

Others who will testify are Dr. Frank Lee, president of the Sacramento Medical Association, and Dr. Charles E. von Geldern of Sacramento.

Government chemists yesterday testified that compound was made up of iron and aluminum sulphate and essentially was a caustic and astringent. Doctor Boscoe of Sacramento testified that neither of the properties could possibly cure cancer, diabetes, venereal diseases, and other ailments as claimed by Isbell.

Prosecuted I Am Case

The case is being prosecuted by W. F. Callahan of Washington, D. C., post office inspector in charge of medical fraud cases who recently prosecuted the I Am cult in Los Angeles. He is assisted by Emmet J. Seawell, assistant United States attorney.

Isbell and the Mandevilles were indicted last February following their arrest by Post Office Inspector George Rolfe.—Sacramento *Bee*, September 16.

* * *

Attorney-General Titles State Medicine Plan

San Francisco, September 8 (AP).—A proposed initiative constitutional amendment providing for free medical and surgical care and hospitalization for all in the state, whenever required, was received by the Attorney-General today with a petition for a circulation title.

It would create a "state department of medical care," with medical, surgical, and maternity care and hospitalization for all classified as a public unity.

The petition was filed by Avery C. Moore of Oakland, who listed himself as author and proponent of the measure.

It was similar in most respects to an amendment he proposed several months ago. This was amended, in present form, to provide for punishment of any person or group attempting to prevent successful functioning of the program, or attempting to injure the professional standing of any member of the professions involved.—Fresno *Bee*, September 8.

* * *

To Your Health

The Giant Cyclotron

I spent yesterday with man who is far more important than Adolf Hitler, and I saw something that is fraught with far more significance to civilization than the German-Russian war. The gentleman was the Nobel Prize winner, Professor E. O. Lawrence, and the thing was the giant cyclotron being set up on the campus of the University of California.

I also saw the smaller cyclotron with which Professor Lawrence did so many things to the atom, many of them of great medical significance. The cyclotron is the instrument which splits up the atom. The modern conception of an atom is that of a field of electric energy. The basic plan of its distinctive divisions—the nucleus and extra-nuclear electrons. The nucleus is composed of protons

and neutrons. Each contains one unit of mass and the protons each have, in addition, one unit of positive electric charge. Outside the nucleus are one or more electrons or units of negative electric charges; they are moving at high speed in a number of different ways; this speed and energy state may be easily changed so they are not stable.

The nucleus, on the contrary, is quite stable. It is the fact that the cyclotron can speed the neutrons with greater energies so that they can be whirled out like a bullet by going around and around between the poles of an electromagnet that gives it major importance in the scientific and medical world today.

The bombardment of neutrons is being used for the treatment of malignant diseases and skin lesion, and although this work is in the experimental stage, it is so hopeful that a large laboratory of medical physics is in process of erection near Professor Lawrence's own laboratory.

The bombardment of various elements with the discharge from the cyclotron imparts radiant energy to them. Thus phosphorus, strontium and iodin can be energized, and put into the body in that form, act just as those chemical elements do in the body anyway.

I was offered a strontium "cocktail" such as those being used for treatment with certain patients. The strontium seeks out the bones; it is probable that if calcium were not so much more abundant that strontium in nature, our bones would have been made of strontium instead of calcium. The strontium atoms are loaded with radiant energy and come to rest in the bone where they release their radiations just as if you put radium all through the bone cells.

In cancer of the bone the cancer is treated *in situ* from thousands of radiation stations. Plants placed in a dark room reveal the life processes of a particular chemical element through the transparent body of the plant. In the human body the process cannot be seen, but by an instrument that allows you to hear chemical reactions the same result is effected. Thus iodin atoms can be tagged, and if the instrument is placed over the thyroid gland a fearful din is heard which consists of the chemical exchange of iodin at that place while other parts of the body are silent.—Dr. Logan Clendening, in the San Francisco *Call-Bulletin*, September 22, 1941.

LETTERS†

Concerning "Resolution of September 16, 1941," in re "Resolution of October 16, 1940."

(COPY)

INDUSTRIAL ACCIDENT COMMISSION
STATE BUILDING
San Francisco, September 18, 1941.

To Whom It May Concern:

On the sixteenth day of September, 1941, the members of the Industrial Accident Commission, in meeting assembled, unanimously passed a resolution, copy of which you will find herein enclosed.

The same is being submitted to you for your perusal and with a request by the Commission that your coöperation may be had with its provisions.

Yours very truly,
(Signed) FRANK J. BURKE,
Secretary.

* * *

Editor's Note: Resolution referred to, with editorial comment, appears in this issue, on page 170.

Concerning an Article on "Health and Defense."

To the Editor:—You may be interested in the bit of publicity sponsored by the Harbor Branch of the Los Angeles County Medical Association in one of our newspapers recently—Long Beach *Independent.*

It was our feeling that rather than publish some inane bit of publicity as our contribution to the anniversary addition of the newspaper, we might use the occasion to reply to some of the vicious antivivisectionist propaganda which is now appearing in the Hearst papers.

I trust that you will find the material interesting and that it meets with your approval.

Very truly yours,
(Signed) K. C. BRANDENBURG, M. D.,
Chairman, Public Relations Committee,
Harbor Branch, Los Angeles County
Medical Association.

* * *

(COPY)

HEALTH . . . AND NATIONAL DEFENSE

Certain well-meaning but misguided individuals and organizations, calling themselves antivivisectioonists, are carrying on a campaign to deprive medical science of its most useful weapon in the battle against disease—animal experimentation—a move which, if successful, would halt the progress of medical science in its tracks, force the drug industry to offer many of its products to the public without any preliminary standardization or testing for purity and potency and cause every embryo surgeon to look for human material on which to learn his art.

The diabolical propaganda, which would have you believe that doctors and medical scientists, who are more concerned about the welfare of human beings and domestic animals than any other group since that is their business, are in reality a group of fiendish Sadists, is deliberately false and misleading.

Without animal experimentation there would be no serums to protect our men in the Army and Navy from typhoid fever, diphtheria, smallpox, yellow fever, and many other conditions which frequently have been more potent in determining the outcome of wars than the battles themselves.

National defense against disease is a constant unspectacular battle being waged by the forces of medical science against pestilence and plague. The antivivisectionists are the fifth columnists and saboteurs who would cripple the efforts of our disease fighters under the guise of humanitarian motives.

The iron lung, which has come to the aid of hundreds of children suffocating with infantile paralysis, cost twenty-four cats. Those opposed to animal experimentation would have you believe that the cats are more important than the children.

What do you think?

Harbor Branch, Los Angeles County
Medical Association

Concerning New Director of Langley Porter Clinic of University of California.

(COPY)

STATE OF CALIFORNIA
DEPARTMENT OF INSTITUTIONS
SACRAMENTO
September 10, 1941.

Governor Culbert L. Olson
State Capitol
Sacramento, California

Dear Governor Olson:

It is with deep satisfaction that I report to you herewith a great forward step that has just been taken in connection with The Langley Porter Clinic in San Francisco.

Dr. Karl Murdock Bowman has been selected, both by the Faculty of the University of California Medical School and the Regents of the University and by the Department of Institutions, for appointment to take charge of the Clinic.

Over a period of more than a year the entire country was carefully scanned for a candidate for the position who might be both suitable and available. At least a dozen names have received careful consideration, but, in the end, the unanimous choice fell on Doctor Bowman.

This will be, undoubtedly, the most important psychiatric position in the Department, and, as provided in the law, he will be employed partly by the University of California in the capacity of head of the Department of Psychiatry there, and partly by the Department of Institutions in the capacity of Medical Superintendent of The Langley Porter Clinic. The salary will be $12,000 per year, half of which shall be paid from the budget of The Langley Porter Clinic and half from the budget of the Department of Psychiatry of the University of California.

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

Doctor Bowman, at the present time, is Director, Division of Psychiatry, New York City Hospitals, and Professor of Psychiatry at New York University. He was born in Topeka, Kansas, in 1888, and received his Medical Degree at the University of California in 1913. It is mainly his desire to return to California that has made it possible for us to secure his services at considerable sacrifice, both financial and otherwise, to himself.

Doctor Bowman is expected to report for duty at The Langley Porter Clinic on or about November 1, 1941.

The building will not have been completed by that time, but it is the best judgment of the Department of Institutions and of the authorities at the University that an early appointment be given him in order that he may have adequate opportunity for selecting personnel for the new institution and arranging all other details of organization.

We were quite happy when we secured appropriations for the erection of The Langley Porter Clinic, but it would have been quite possible for a first-class building to be constructed and equipped, and the whole enterprise to be a failure, through an improper selection of a person to take charge of the enterprise. The State of California has now been insured against such a mishap as that.

Very sincerely yours,

AARON J. ROSANOFF.

Concerning State Health Board Resolutions Regarding Diabetes.

To the Editor:—Attached resolution passed by the State Board of Health on September 13 will be of interest to you.

We are delighted with the interest shown by secretaries of county societies throughout the State in the diabetes program. Strange to say, the death rate from diabetes is already showing a slight reduction, though it is too early to hazard a guess as to whether it is the beginning of a downward trend or merely due to some artifact.

With best regards,

Sincerely yours,

(Signed) W. P. SHEPARD, M. D.

* * *

(COPY)

Excerpt from Minutes of September 13, 1941, Meeting of the California State Board of Public Health

WHEREAS, The aging of our population brings all degenerative diseases into sharp relief; and

WHEREAS, Diabetes, among such diseases, is particularly amenable to scientific methods now available for its control; and

WHEREAS, A campaign of education in diabetes control is being undertaken by the Metropolitan Life Insurance Company among doctors of medicine, health officers, and interested laymen; and

WHEREAS, The possibilities of life extension in diabetes, under modern methods of control, place it among those diseases that are, to a degree, preventable; now, therefore, be it

Resolved, That the California State Board of Public Health hereby gives its full endorsement to this campaign of education in diabetes and sanctions all efforts to extend it throughout the State.

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.

San Francisco

Malpractice: Time Within Which Suit May Be Commenced—Effect of Failure of Vasectomy to Accomplish Purpose

Ordinarily, a patient who believes that he has been injured in some manner by actions or omissions of his physician must commence action within one year from the date of the actions or omissions. If suit is filed after a year has passed, the complaint is usually subject to the defense of the statute of limitations.

There is one exception to the foregoing rule of law, namely: If the physician has concealed his alleged negligent actions or omissions, the one-year period does not commence to run until *after* the patient has discovered the true facts or until *after* he obtains such knowledge as would put an ordinary person on inquiry.

For a full discussion of the satute of limitations in malpractice actions and the exception to the one-year rule, see CALIFORNIA AND WESTERN MEDICINE, March, 1937, page 204, and February, 1939, page 163.

A very recent California case presents a new and very important phase of the general problems relating to the one-year period of limitation. The case is *Bathke* vs. *Rahn*, 46 A. C. A. 776, decided on September 3, 1941. The facts therein concerned were: Plaintiff, a married man, consulted the defendant physician to obtain professional aid in the avoidance of future pregnancies of his wife. His wife, after bearing four children, had suffered a complete physical and nervous breakdown and her health did not permit future pregnancies. The defendant physician advised a double vasectomy and stated that the operation would sterilize the plaintiff and would not injuriously affect his ability to carry on his occupation. Plaintiff was a traveling salesman. The operation was performed in October, 1938. More than a year later plaintiff commenced a malpractice action against the physician, claiming, first, that his wife had again become pregnant, and, second, that the vasectomy had caused a nervous disorder resulting in his inability to continue his occupation.

On these facts, the defendant physician urged the statute of limitations. The court disagreed with plaintiff's argument that the case was within the exception to the one-year rule. The court said that concealment was not present because once the plaintiff became nervous he was put upon notice that something was wrong and he should have made inquiry to determine whether or not the vasectomy caused his difficulties. In other words, the court applied the rule that means of knowledge is the equivalent of knowledge. Applying this rule, the case was not within the exception because the plaintiff was not without knowledge of the alleged malpractice.

One other phase of the case merits close attention. It will be recalled that the wife became pregnant about eleven months after the operation. The court indicated that if suit had been commenced for malpractice, based on the pregnancy alone rather than upon the husband's nervous disorder, a cause of action would have been stated. The court reasoned in the following manner: The physician warranted that vasectomy would sterilize the patient. The operation did not result in sterilization. This being so, it was a breach of promise or a breach of warranty when the wife again became pregnant. For this breach of warranty the physician could be held answerable in damages.

In order to avoid controversy and possible malpractice action by a patient upon whom a vasectomy has been performed, physicians should, prior to undertaking the operation, fully and clearly explain to the patient the present medical knowledge on the subject of vasectomy and the relative chance, whatever it may be, of failure of the operation to accomplish its purpose. If possible, the foregoing explanation should be made in the presence of another physician and in the presence of the spouse of the patient, particularly if the health of the spouse may be affected by the results of the operation. Under no circumstances should a patient be promised sterility as a certainty *unless* the physician is willing to take the consequences of a future pregnancy of the patient's wife.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XIV, No. 10, October, 1916

EXCERPTS FROM EDITORIAL NOTES

Indemnity Funds.—Do not allow the opportunity of participating in the Malpractice Indemnity Fund to escape you. The whole plan in detail was printed in the July *Journal.* Briefly put, it is that if three hundred or more members participate, a trust fund will be created, out of which fund settlements out of court, or the payments of judgments against such contributing members will be met. This gives you, in addition to the defense protection of the State Society which every member naturally has, complete financial protection, and the Lord knows you need it! If three hundred members will each send in their check for $15, and promissory note payable one year after date for a like amount, the fund will come into existence and the plan be put in operation. Since the first of the year hardly a week has passed in which a member has not been sued, and not a single day has passed in which some manner of complaint, suit, threat, or correspondence relating to these matters, has not gone through the office of the Society. We figure that if enough members will come into the fund, assessments will be required not oftener than every four or five years, and thus our members can practically carry their own insurance at a minimum cost and at a cost very much less than that of insurance in any indemnity company.

Annual Meeting at Coronado.—The next annual meeting of the State Society will be held at Coronado, and as there will be ample accommodations under one hotel roof for at least five hundred, we may have no anxiety as to lack of accommodations. We are advised by the secretary of the committee in charge that a large assembly hall will be provided for the general meetings, and rooms enough for sections meeting at the same time within the hotel itself. . . .

Important Notice.—The Committee on Scientific Work wishes to call the attention of the members of the Society to the necessity of sending in early the titles to papers which they wish to present at the annual meeting to be held in April. Each year makes it increasingly difficult to include in the program the number of papers which are presented. It is, therefore, of importance that those intending to present papers notify the office at the earliest possible moment.

In order to avoid criticism, and in order that there may be no feeling that injustice has been done anyone, we wish to call attention to certain rulings that have been made by previous committees and which will be strictly adhered to in future. . . .

Social Insurance.— Physicians, after all, are merely human beings, and as a rule they act and behave very much as other human beings do. When we see that large numbers of business men have never heard that there is a State Commission for the Study of Social Insurance and have no idea what it means, what it purports, or what the object of it is, we need not be surprised that large numbers of physicians also do not understand what is going on. Indeed, many of those who are actively participating in the new sociologic experiments do not themselves realize the extent of the movement or the far-reaching changes that

(Continued in Front Advertising Section, Page 14)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.
Secretary-Treasurer

News

"Arraigned on bunco charges late yesterday, Temple Terrell Turner, fifty-six, of 463 East Olive Avenue, pleaded not guilty and asked for a jury trial. . . . Turner was arrested at the office of a local chiropractor Monday by an investigator from the State Medical Board. The charges grew out of a complaint filed by a local woman who reportedly paid $300 for a 'cancer treatment.' . . . Dr. B. F. Badgeley, arrested on similar charges in the raid, was not arraigned yesterday." (Burbank *Review,* August 27, 1941.)

"Dr. William Peters, sixty-eight, of Nicasio, has been charged with a hit-run felony for leaving the scene of a crash at the Greenbrae junction of highway 101 in Marin County. In the accident, Chloe Gartner of Larkspur, a librarian at the *Chronicle,* was seriously injured. . . . Miss Gartner told police Doctor Peters did not stop after striking the car in which she was a passenger. . . . The police said that 'even though Doctor Peters was a physician, he did not aid Miss Gartner, who was seriously injured.' Doctor Peters said he gave Mrs. Moore his name and address before driving away. This Mrs. Moore and Miss Gartner denied." (San Francisco *Chronicle,* August 30, 1941.)

"Emphatic opposition to the pardon application of Dr. Nathan S. Housman, San Francisco physician now seeking to clear his record of narcotics and perjury charges, was expressed yesterday by District Attorney Brady. Housman served seventy-five days in the County Jail for failing to keep proper records of narcotics prescriptions and was fined $750. Outgrowth of his stormy Municipal Court trial was his subsequent conviction on perjury charges. Conviction on the former charges was upheld by the District Court of Appeal and is still pending on the latter." (San Francisco *Chronicle,* September 9, 1941.)

"Herman Dudley Abrams, self-styled doctor, was ordered held for superior court trial yesterday on forty-six counts of grand theft after various witnesses accused him of swindling them of $27,000. His method, they told Municipal Judge Charles B. MacCoy, was to beguile them with tall tales of his 'healing clay,' his intimacy with numerous Hollywood film stars, and as a confidant of men of science. Ralph Hickman, Hollywood insurance company executive and his wife, Ellen, testified that they invested $27,000 in his ventures after he told them he had a trust fund of $300,000, but needed funds for 'secret studies.' A bank executive refuted the trust fund story and a Red Cross worker denied Abrams' reputed claim that he planned to give $10,000 to the organization. . . . Among the grievances of the Hickmans was the charge that they advanced Abrams $15,000 to publish scientific treatises, which were never published. . . . The Hickmans declared Abrams told them he was collaborating with Dr. Robert A. Millikan, head of California Institute of Technology. Doctor Millikan testified on Tuesday he never collaborated with Abrams 'on anything.'" (Los Angeles *News,* August 21, 1941.)

(Continued in Front Advertising Section, Page 26)

†The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

How to Use S-M-A Powder

EACH PACKAGE OF S-M-A* CONTAINS ONE MEASURING CUP

1 Empty one tightly packed measuring cup of S-M-A powder into bottle.

2 Add enough warm previously boiled water to make one ounce.

3 Cap bottle and shake powder into solution. Feed at body temperature.

4 Easy, isn't it?

S-M-A READY TO FEED PROVIDES:

● 20 calories to the ounce, but more important, the nutritional value of S-M-A is that of a complete well-balanced food. When prepared as above, each quart provides:

10 mg. Iron and Ammonium Citrate
200 I. U. of vitamin B_1
400 I. U. of vitamin D
7500 I. U. of vitamin A

NORMAL INFANTS RELISH S-M-A—DIGEST IT EASILY AND THRIVE ON IT

*S-M-A, a trade mark of S-M-A Corporation, for its brand of food especially prepared for infant feeding—derived from tuberculin-tested cow's milk, the fat of which is replaced by animal and vegetable fats, including biologically tested cod liver oil; with the addition of milk sugar and potassium chloride; altogether forming an antirachitic food. When diluted according to directions, it is essentially similar to human milk in percentages of protein, fat, carbohydrate and ash, in chemical constants of the fat and physical properties.

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"He can still chew but He can't swaller"

It's an old Hoosier saying, often as true of the patient with superficial oral or pharyngeal pathology as of young gluttons. For the former, however, there is usually relief . . . NUPORALS, "Ciba."

NUPORALS,* containing one mgm. of Nupercaine in each lozenge are effective in allaying pain and tenderness of the oral and faucial mucous membranes; especially are they indicated for ameliorating the pharyngeal distress associated with passing stomach tubes. Non-narcotic, locally anesthetic and pleasant to taste.

NUPORALS are supplied in boxes of 15 and in bottles of 100 lozenges. Samples and more details upon request.

*Trade Mark Reg. U. S. Pat. Off. The word "Nuporals" identifies throat lozenges of Ciba's manufacture, each lozenge containing one mgm. of Nupercaine, "Ciba."

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CIBA PHARMACEUTICAL PRODUCTS, INC.
SUMMIT, NEW JERSEY

BOARD OF MEDICAL EXAMINERS

(Continued from Front Advertising Section, Page 26)

with a rogue's gallery shot of the cracker named Brownlow. Florida officers caught up with him at the swampland home of his sister, whom they decided to contact after checking the suspect's prison record. It developed that Brownlow was in Los Angeles at the time he met Doctor Martin as a guest of the Salvation Army, the organization to which he was paroled following his release from Oahu penitentiary, Hawaii. . . ." (Los Angeles *News*, August 15, 1941.)

"The three-judge appellate division of the local superior court yesterday took under submission St. Louis Estes' appeal from his conviction on ten counts of violating the State's Medical Practice Act. Estes, free on bail since the conviction before a jury last September in Municipal Judge J. E. White's court, faces a fine totaling $2,500 and 150 days in jail unless he wins a reversal. Estes has had frequent skirmishes with the law here over his lectures relating to raw food diets. In this case he was accused by Arthur W. Derrickson of 1455 Clay Street of prescribing remedies for his failing eyesight. Oral arguments on the appeal were presented to Judges Franklin Griffin, Thomas Foley and Robert McWilliams by Joseph Brown, for Estes, and by Deputy District Attorneys Ben Lerer and Arthur Jonas." (San Francisco *Examiner*, August 16, 1941.)

"Dr. Albert W. Richardson, sixty-nine, owner of the California Chiropractic College in Long Beach, yesterday was ordered by Municipal Judge Charles B. MacCoy to stand Superior Court trial on charges of violating the Business and Professions Code. At the defendant's preliminary examination, Deputy District Attorney Evan Lewis introduced evidence alleging that Doctor Richardson made a false affidavit regarding the number of hours studied by a student at the school. Judge MacCoy released the educator under $1,000 bond to await arraignment in the higher court." (Los Angeles *Times*, August 14, 1941.)

"Governor Olson today had named Eugene O. Darnall of Berkeley and Edward W. Davidson of Los Angeles to two-year terms on the State Board of Osteopathic Examiners. Darnall succeeds Edward B. Jones of Los Angeles, and Davison replaces Warren B. Davis of Long Beach." (Press dispatch dated Sacramento, August 7, and printed in the Pasadena *Star-News*, August 7, 1941.)

"Shortly before he was to be sworn in as a medical officer in the United States Navy, Dr. Walter W. Webb, thirty-five, formerly of Seattle, was arrested in Vallejo by federal officers on charges of selling narcotics. In a removal complaint filed before United States Commissioner Ernest E. Williams by Assistant United States Attorney James T. Davis, Webb was charged with sales of morphin and cocain in Seattle between last June 28 and July 1. He was taken to San Francisco County Jail and held in lieu of $1,000 bail." (Press dispatch dated Vallejo, September 9, and printed in the Sacramento *Bee*, same date.)

We must come to realize that only by understanding the history, culture, and customs of those who live in distant lands can we really begin to know them—George F. Zook, President, American Council on Education.

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33⅓% Fewer Calories

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Recent tests by a leading impartial research laboratory, reveal that 8 ounces of ACME BEER contain 33⅓% fewer calories than the average of 53 popular diet foods in normal individual servings. So, it's true you *can* count the calories you consume and guard your weight, yet still enjoy a glass of sparkling, delicious Acme Beer.

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FOOD	Calories per 100 grams
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Banana	125
Melba Toast	400
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ACME BEER only 44 Calories Per 100 Grams

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Now EVERY Doctor Can Fit a Pessary

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The BACH CERVICAL CAP PESSARY provides an easy, non-injurious, efficient method of contraception which, with the BACH PESSALATOR (applicator), can be utilized by any qualified physician.

There are three sizes: regular, medium and large, but the "regular" size will usually fit the average normal cervix.

PRICE: BACH PESSARY and BACH PESSALATOR—$1.50 each. Samples, limited to 6, 60c for Pessary and 60c for Pessalator.

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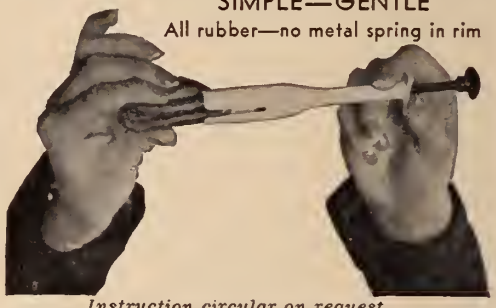

Instruction circular on request

MEDICAL EPONYM

Hodgkin's Disease

Thomas Hodgkin (1798-1866), pathologist at Guy's Hospital, London, wrote a paper, "On Some Morbid Appearances of the Absorbent Glands and Spleen," which was presented at a meeting of the Medical and Chirurgical Society of London on January 10 and 24, 1832, and printed in the *Medico-Chirurgical Transactions: Published by the Medical and Chirurgical Society, London* (17:68-114, 1832). This treatise consists of a series of seven autopsy protocols and two case reports. Probable cases of tuberculous adenitis and leukemia were included in the series.

"It may be observed that notwithstanding some differences in structure, . . . all these cases agree in the remarkable enlargement of the absorbent glands accompanying the larger arteries, namely, the glandulae concatenatae in the neck, the axillary and inguinal glands, and those accompanying the aorta in the thorax and abdomen . . . this enlargement appeared to be a primitive affection of those bodies, rather than the result of an irritation propagated to them from some ulcerated surface or other inflamed texture through the medium of their inferent vessels. . . . Unless the word 'inflammation' be allowed to have a more indefinite and loose meaning than is generally assigned to it, this affection of the glands can scarcely be attributed to that cause, since they are unattended with pain, heat, and other ordinary symptoms of inflammation, and are not necessarily accompanied by any alteration in the cellular or other surrounding structures, and do not shew any disposition to go on to the production of pus or any other acknowledged product of inflammation. . . ."—R. W. B., in *New England Journal of Medicine*, Vol. 224, No. 22, May 29, 1941.

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Just call or write the Clinic—THE DOCTORS BUSINESS BUREAU—at the office most convenient to you: Spreckels Building, Los Angeles; 153 Kearny Street, San Francisco; Times Building, Long Beach, or Latham Square Building, Oakland.

THE CALIFORNIA SANATORIUM

Fully equipped for the diagnosis and modern treatment of diseases of the chest, including tuberculosis and other respiratory diseases.

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Resident Clinicians

Mere Calory Counting Is Futile as a Means of Reducing Weight.—Counting calories as a means of reducing weight is futile and may be dangerous unless accompanied by a knowledge of the ingredients and constituents in the foods consumed, Amalia Lautz, Ph. D., Chicago, advises in *Hygeia, The Health Magazine*. Her article outlines a healthful and effective guide to weight reducing.

The author warns that disastrous physical and nervous conditions may result from weight reduction, especially from rapid reduction. To prevent such results, she advises that one who wishes to reduce should have: (1) a thorough medical examination; (2) a daily diet rich in all food constituents, except energy; (3) a food intake in which the energy value or calories total less than those expended; (4) a check on the actual calories secured, by intelligent weighing; and (5) examination by a physician after weight has been lost to determine the physical and nervous effects of reduction and the advisability of its continuance.

"Because the total amount of food [in the diet] must be limited in energy," Doctor Lautz declares, "a special effort to make the diet nutritionally adequate otherwise is necessary. Minerals and vitamins commonly deficient and other substances must be fully supplied. In order to remain healthy, the body must receive a full quota of complete protein, calcium, phosphorus, iron, iodin, vitamin A or carotene, B vitamins including thiamin, nicotinic acid and riboflavin, and vitamins C and D, which are frequently found low in the American diet."

To insure this quota, Doctor Lautz recommends that the following foods be included in the diet each day:

"Two or three servings of lean meat and eggs . . . three servings of raw nonstarchy fruit . . . as many green leafy

vegetables—for vitamin A—and other nonstarchy vegetables as can be eaten . . . two glasses of whole milk . . . not more than three servings of whole wheat bread, potatoes, or bananas . . . not more than three teaspoons or restaurant servings of butter . . . or three tablespoons of thin cream . . . iodized table salt for iodin, if not living near the sea.

"About 1,200 to 1,600 calories a day are provided by the foods listed if taken raw or plainly cooked, that is, boiled, baked, steamed, broiled, or roasted, without additions of fats, oils, sugar, flour, or other high caloric foods."

The author advises that tea with lemon, black coffee without sugar, or thin, clear, fat-free soups may be used in any quantity desired. Vinegar and seasonings aid palatability without increasing calories, although salt may increase the weight temporarily, due to the fact that it helps retain water in the body. She warns against the use of "nonfattening" salad dressings which contain oil because of the laxative quality of the oil, which dissolves fat-soluble vitamins such as A and D and carries them out of the body without absorption or utilization.

Fats and oils, sugars and syrups, dry foods in general and starchy foods are to be avoided in dieting, because these are concentrated sources of food energy, high in calories and fattening.

"The average amount of energy required by a man doing physically inactive work without exercise," Doctor Lautz says, "is about 2,400 calories a day; a sedentary woman needs about 2,100 calories for the same length of time. Food furnishing fewer calories than the amount expended by the body will decrease the body weight. However, the actual energy output of each person varies greatly."

The writer enumerates the various factors that determine the energy output of each person. She names physical activity as one important source of the burning of body substances. Tenseness, she asserts, is another energy expender. The inability to sleep and rest in a relaxed manner increases the energy output and, consequently, the calories required from food to keep weight constant.

The author contends that the amount of food each person must eat habitually to keep his weight constant or to lose weight is most effectively indicated by weighing oneself at sufficiently long intervals on the same accurate scales. Weighing should take place at the same time of day and with the same relation to meals to obtain the most accurate check on reduction. Gradual weight loss is, according to the author, usually the best procedure.

"To achieve good results in weight reduction," Doctor Lautz concludes, "eat first the essential basic foods which will furnish you with the minerals, vitamins, and other food substances you need. Avoid fatty, sweet, dry and starchy foods in the order given. Then find the amount of these high energy foods you need by what you weigh, and thus let the scales check your calories."

"Depression or No Depression, War or No War."—Since 1930, month after month, a unique series of educational-to-the-public advertisements have appeared on the first page of *Hygeia*. The sponsor's name, Mead Johnson & Company, has to be looked for with a magnifying glass, and appears only for copyright purposes. Not a product is ballyhooed. Instead, appear good, clean, convincing reasons, with choice illustrations, why mothers should seek pediatric advice *from their physicians.*

Few things are more important to a community than the health of its women, says a proverb, the son will give laws to the people. And in nations where all men give laws, all men need mothers of strong frames.—Higginson.

Colfax School for the Tuberculous

COLFAX, CALIFORNIA

There are two units, The Colfax Hospital and the Bushnell Sanatorium, for the treatment of Pulmonary Tuberculosis.

The Colfax School for the Tuberculous is located in the pine clad Sierra Nevada foothills, at an elevation of 2,400 feet; an elevation free from the fogs of the valleys and free from extremes of heat or cold.

This Institution supplies, among other advantages:

1. Individual care and supervision under skilled physicians.
2. Education as to the essentials of recovery from, and the prevention of the spread of, disease.
3. Complete laboratory and x-ray equipment.
4. Every proved method of treatment, including pneumothorax and phenric nerve interruption. (Major thoracic surgery referred to skilled thoracic surgeons.)
5. An absence of institutional atmosphere.
6. Reasonable rates.

▾ ▾ ▾

For further information write

ROBERT A. PEERS, M.D.
Medical Director
COLFAX, CALIFORNIA

▾ ▾ ▾

F. LYNN SMITH, M.D.
Associate Medical Director

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MEDICAL EPONYM

Hunterian Chancre

On page 218 of the volume, *A Treatise on the Venereal Disease* (London, 1786) by John Hunter) 1728-1793), the following description appears:

"This, like most other inflammations which terminate in ulcers, begins, first, with an itching in the part; if it is the glans that is inflamed, generally a small pimple appears full of matter, without much hardness, or seeming inflammation, and with very little tumefaction, the glans not being so readily tumefied from inflammation as many parts are, especially the prepuce; nor are the chancres attended with so much pain or inconvenience, as those on the prepuce; but if upon the fraenum, and more especially the prepuce, an inflammation more considerable than the former soon follows.... The itching is gradually changed

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to pain; the surface of the prepuce is in some cases excoriated, and afterwards ulcerates; in others a small pimple, or abscess, appears as on the glans, which forms an ulcer. A thickening of the part comes on, which at first, and while of the true venereal kind, is very circumscribed, not diffusing itself gradually and imperceptibly into the surrounding parts, but terminating rather abruptly. Its base is hard, and the edges a little prominent. When it begins on the fraenum, or near it, that part is very commonly wholly destroyed, or a hole is often ulcerated through it."—R. W. B., in *New England Journal of Medicine*, Vol. 224, No. 26.

MEDICAL EPONYM

Hutchinsonian Teeth

On May 18, 1858, Jonathan Hutchinson (1828-1913) presented "Report on the Effects of Infantile Syphilis in Marring the Development of the Teeth" before the Pathological Society of London. This paper appears in the *Transactions of the Pathological Society of London* (9:449-455, 1858).

"For a considerable time past, I have been in the habit of recognising in a certain very peculiar development of the permanent teeth an indication that their possessor had in infancy suffered from hereditary syphilis. . . . I will now pass to the conclusions arrived at.

". . . *There is a peculiar condition of the teeth, which results from the influence of hereditary syphilis, and . . . the most frequent features of this condition are the following:* (a) *Smallness.*—The teeth stand apart with interspaces, and are rounded and peggy in form instead of flat. (b) *Notching.*—They usually exhibit in their border a broad shallow notch, or at times, two or three (serrated). Owing to their softness, these teeth rapidly wear away, and this notching is thus often obliterated, but when markedly present it is one of the most decisive conditions. (d) *Colour.*—Instead of the clear, smooth, white exterior of good teeth, they present a dirty greyish surface, totally destitute of polish and rarely smooth. No amount of cleaning will materially alter this feature which owes its existence, I believe, to the great deficiency of enamel. (e) *Wearing Down.*—As before observed, their softness from deficiency of enamel renders them liable to premature wearing down. . . . (f) The signs mentioned apply almost exclusively to the incisors and canines and in fact the grinders are usually altered in a very much less degree.

(Continued on Next Page)

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(Continued from Preceding Page)

Their surfaces are often more uneven than those of healthy teeth, and now and then they present tubercular projections of a very peculiar character. . . . The above remarks apply only to the permanent set."—R. W. B., in *New England Journal of Medicine*, Vol. 225, No. 3, July 17, 1941.

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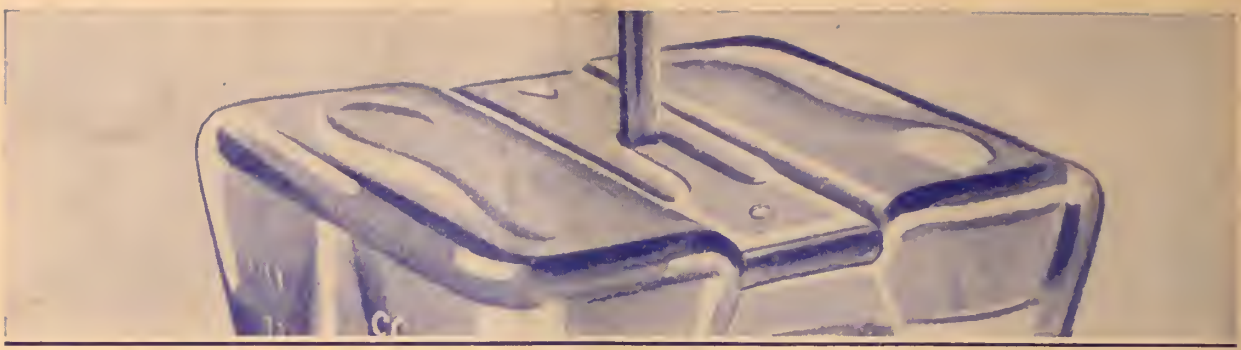

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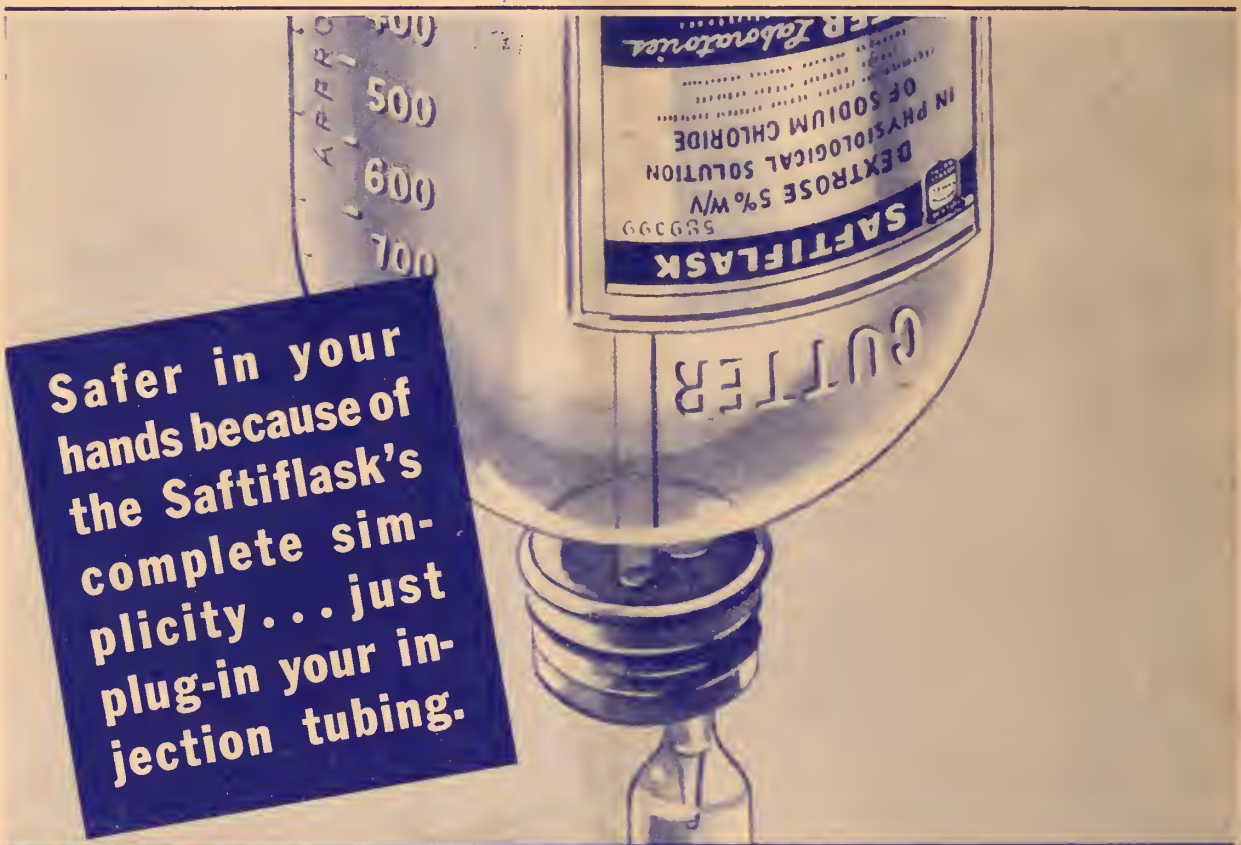

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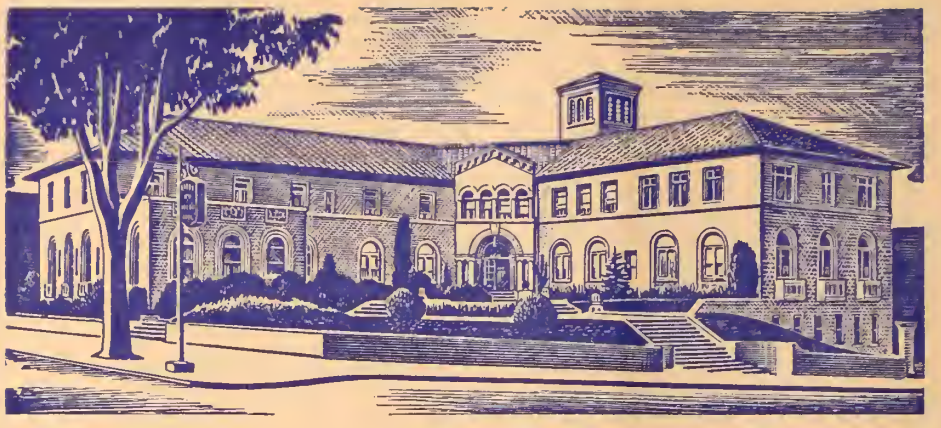

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ROSTER OF COUNTY MEDICAL SOCIETIES, CALIFORNIA MEDICAL ASSOCIATION

(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association
2404 Broadway, Oakland
President, John W. Sherrick, 350 Twenty-ninth Street, Oakland.
Secretary, Gertrude Moore, 353 30th Street, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn County Medical Society
President, Charles Benninger, Jr., Oroville.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, R. J. P. Harmon, 314 Tenth Street, Richmond.
Secretary, L. Abbott Hedges, 912 Macdonald Avenue, Richmond.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, Frank R. Ruff, 1234 S Street, Fresno.
Secretary, J. E. Young, 405 Rowell Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, Lowell G. Kramar, 1049 Main Street, Fortuna.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, William A. Clarke, 132 Fifth Street, Holtville.
Secretary, Claude F. Peters, 722 Main Street, El Centro.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, H. W. Crook, 106 S. Main, Bishop.
Secretary, George Shultz, 124 N. Main, Lone Pine.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society
President, Lucille B. May, 1706 Chester Ave., Bakersfield.
Secretary, Sophie M. Loven, 458 Haberfelde Building, Bakersfield.
Meeting, *Third Thursday, 8:00 p. m.*

Kings County Medical Society
President, Lionel W. Sorenson, 1118 Whitley Avenue, Corcoran.
Secretary, Arthur Zeismer, 410 N. Irwin Street, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, W. B. McKnight, Portola.
Secretary, Bernard S. Holm, Quincy.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles
President, Thomas C. Myers, 1501 So. Figueroa Street, Los Angeles.
Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, Wilson P. Goddard, 308 Throckmorton Street, Mill Valley.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, Deer Park Villa, Fairfax.*

Mendocino-Lake County Medical Society
President, Royal Scudder, 123 Laurel Street, Fort Bragg.
Secretary, Otto L. Gericke, Mendocino State Hospital, Talmage.
Meeting, *on Call.*

Merced County Medical Society
President, A. B. Bigler, 165 N. Second Street, Chowchilla.
Secretary, James A. Parker, Bank of America Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, James McPharlin, 8 East Alisal Street, Salinas.
Secretary, R. D. Mace, 601 South Main Street, Salinas.
Meeting, *First Thursday.*

Napa County Medical Society
President, R. C. Burkett, 1130 First Street, Napa.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Association
President, Lawrence C. Cameron, 218 South Main Street, Santa Ana.
Secretary, Milo K. Tedstrom, 1626 Bush Street, Santa Ana.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer-Nevada-Sierra County Medical Society
President, Lucas W. Empey, Roseville.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Wayne K. Templeton, 3770 Twelfth Street, Riverside.
Secretary, Hobart M. Kelly, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital*

Sacramento Society for Medical Improvement
President, Frank Warne Lee, 510 Physicians Building, Sacramento.
Secretary, Curtis H. McDonnell, California State Life Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Edward H. Risley, Loma Linda.
Secretary, Arthur E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital*

San Diego County Medical Society
1410 Medico-Dental Building, 233 A Street, San Diego
President, Frank A. St. Sure, 4067 Van Dyke Avenue, San Diego.
Secretary, W. H. Geistweit, Jr., 810 Medical Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
2180 Washington Street, San Francisco
President, Harold A. Fletcher, 490 Post Street, San Francisco.
Secretary, L. Henry Garland, 2180 Washington Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, Raymond Leroy Owens, 28 Cory Building, Lodi.
Secretary, George H. Rohrbacher, 1005 Medico-Dental Building, Stockton
Acting Secretary, C. A. Broaddus, 242 North Sutter Street, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton*

San Luis Obispo County Medical Society
President, Horace Hagan, 1215 Chorro Street, San Luis Obispo.
Secretary, E. M. Bingham, County Health Department, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, H. H. Whitney, 1204 Burlingame Avenue, Burlingame.
Secretary, Thomas Farthing, 23 Second Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, H. R. Schwalenberg, Cottage Hospital, Santa Barbara.
Secretary, D. H. McNamara, 317 W. Pueblo Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society
President, A. J. Baiocchi, 369 South Third Street, San Jose.
Secretary, Leon P. Fox, Ste. Claire Building, San Jose.
Meeting, *Third Monday, 7:00 p. m., Sainte Claire Hotel, San Jose.*

Santa Cruz County Medical Society
President, Avery Wood, 335 Main Street, Watsonville.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meeting, *First Tuesday of each month (except June, July and August), 7:30 p. m., Club Rio del Mar, Aptos.*

Shasta County Medical Society
President, Earnest Dozier, Redding.
Secretary, Julius M. Kehoe, Redding.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, F. W. Martin, 106 Orem Street, Mt. Shasta.
Secretary, Victor W. Hart, 113 No. Oregon Street, Yreka.
Meeting, *Sunday on call.*

Solano County Medical Society
President, Gordon Bunney, Suisun.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Tuesday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, Leighton Ray, 536 B Street, Santa Rosa.
Secretary, John O. Raffety, 505 B Street, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Hoyt R. Gant, 1024 J Street, Modesto.
Secretary, A. E. Ghilotti, 1024 J Street, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
President, R. G. Frey, Red Bluff.
Secretary, F. J. Bailey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Ray E. Cronemiller, 160 South E Street, Exeter.
Secretary, Forrest G. Powell, 222 W. Willow Street, Visalia.
Meeting, *Sunday Evening once a month*

Ventura County Medical Society
President, James W. Moore, 23 S. California Street, Ventura.
Secretary, Robert K. Harker, 132 Fourth Street, Oxnard.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, Edwin K. Copeland, 405 First Street, Woodland.
Secretary, Wilfred T. Robbins, 719 Second Street, Davis.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society
President, Romayne B. Whitney, Plumas Street, Yuba City.
Secretary, Leon M. Swift, I. O. O. F. Building, Marysville.
Meeting, *Second Wednesday.*

(Roster lists continued on advertising page 6)

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1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," Am. J. Syph., Gon. & Ven. Dis., 23, 201 (March), 1939.

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California Packet Library Services

In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco.

Barlow Medical Library (Los Angeles County Medical Association), 634 South Westlake, Los Angeles.

Nonprofit Hospitalization Corporations

In California, the three nonprofit hospitalization corporations named below are in operation:

Hospital Service of California, 333 Pine Street, San Francisco; 675 East Santa Clara, San Jose; 364 Fourteenth Street, Oakland.

Associated Hospital Service of Southern California, 1151 South Broadway, Los Angeles.

Intercoast Hospitalization Insurance Association, 1127 "J" Street, Sacramento.

Acute Respiratory Infections.—In the May issue of *Southwestern Medicine*, a preliminary report of Doctors Maxwell R. Palmer and Jerome E. Andes of Tucson describes the successful relief of colds and acute upper respiratory infections, using "Vacagen" Oral Cold Vaccine Tablets, manufactured by Sharp & Dohme.

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Request is made that any member who desires to submit papers before an annual session section, write in regard thereto, to respective section secretary, as soon as convenient after the close of an annual session.

Anesthesiology

Chairman, Dorothy Wood, University of California Hospital, San Francisco.
Secretary, Ernest H. Warnock, 1136 West Sixth Street, Los Angeles.

Dermatology and Syphilology

Chairman, Henry Sutherland Campbell, 1930 Wilshire Boulevard, Los Angeles.
Vice-Chairman, Herman V. Allington, 3115 Webster Street, Oakland.
Secretary, Thomas Walker Nisbet, 65 North Madison Avenue, Pasadena.

Eye, Ear, Nose and Throat

Chairman, Warren D. Horner, 490 Post Street, San Francisco.
Vice-Chairman, George McClure, 411 Thirtieth Street, Oakland.
Secretary, Ferris L. Arnold, 923 Security Building, Long Beach.

General Medicine

Cbairman, E. Richmond Ware, 416 Wilshire Medical Building, 1930 Wilshire Boulevard, Los Angeles.
Secretary, Garnett Cheney, 703 Shreve Building, 210 Post Street, San Francisco.
Assistant Secretary, Mast Wolfson, 215 Franklin Street, Monterey.

General Surgery

Chairman, E. Eric Larson, 1930 Wilshire Boulevard, Los Angeles.
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Assistant Secretary, J. Norton Nichols, 1930 Wilshire Boulevard, Los Angeles.

Industrial Medicine and Surgery

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Secretary, Leonard B. Barnard, 2939 Summit Street, Oakland.

Neuropsychiatry

Chairman, James A. Cutting, Agnew State Hospital, Agnew.
Secretary, Karl Otto von Hagen, 727 West Seventh Street, Los Angeles.

Obstetrics and Gynecology

Chairman, C. F. Fluhmann, Stanford University Hospital, San Francisco.
Vice-Chairman, Norman H. Williams, 415 North Camden Drive, Beverly Hills.
Secretary, Philip H. Arnot, 490 Post Street, San Francisco.

Pathology and Bacteriology

Chairman, Howard Ball, 233 A Street, San Diego.
Secretary, Jesse L. Carr, University of California Hospital, San Francisco.
Assistant Secretary, L. J. Tragerman, 657 South Westlake Avenue, Los Angeles.

Pediatrics

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Secretary, E. H. Christopherson, 420 Walnut Avenue, San Diego.
Assistant Secretary, William Anthony Reilly, 384 Post Street, San Francisco.

Radiology

Chairman, Wilbur Bailey, 2009 Wilshire Boulevard, Los Angeles.
Secretary, Joseph D. Coate, Peralta Hospital, Oakland.

Urology

Chairman, Edward W. Beach, 1127 11th Street, Sacramento.
Secretary, Wirt Dakin, 802 Pacific Mutual Building, Los Angeles.

California Medical Association Delegates and Alternates to the American Medical Association

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Treasurer, Mrs. Edmund J. Morrissey, 2540 Filbert Street, San Francisco.

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Butte-Glenn County—President, Mrs. C. C. Landis, 1081 Woodland Avenue, Chico.
Contra Costa County—President, Mrs. Thomas Dozier, 507 Tenth Street, Antioch.
Fresno County—President, Mrs. J. R. Walker, Rt. 3, Box 528, Fresno.
Humboldt County—President, Mrs. Allan Watson, 2317 D Street, Eureka.
Inyo-Mono County—President, Mrs. H. W. Crook, 106 South Main, Bishop.
Kern County—President, Mrs. C. I. Mead, 2830 Eighteenth Street, Bakersfield.
Kings County—President, Mrs. C. G. Newbecker, 1604 Whitmore Street, Hanford.
Lassen-Plumas-Modoc County—President, Mrs. Fred J. Davis, Jr., 920 Pine Avenue, Susanville.
Los Angeles County—President, Mrs. William C. Boeck, 712 North Maple Drive, Los Angeles.
Marin County—President, Mrs. H. N. Hensler, Box 244, San Rafael.
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Riverside County—President, Mrs. Frederick Veitch, 3660 Fourteenth Street, Riverside.
Sacramento County—President, Mrs. Gustave Wilson, 2023 Twenty-third Street, Sacramento.
San Diego County—President, Mrs. E. H. Christopherson, 2876 Nutmeg, San Diego.
San Francisco County—President, Mrs. E. S. Kilgore, 2417 Green Street, San Francisco.
San Joaquin County—President, Mrs. Edmund Halley, 1101 Vernal Way, Stockton.
San Luis Obispo County—President, Mrs. Horace Hagen, 1333 Mills Street, San Luis Obispo.
San Mateo County—President, Mrs. Otis Allen Sharpe, 617 Crescent Ave., San Mateo.
Santa Barbara County—President, Mrs. C. W. Henderson, 130 E. Pedregosa Street, Santa Barbara.
Santa Clara County—President, Mrs. George A. Gray, 1248 Martin Street, San Jose.
Santa Cruz County—President, Mrs. Norman Sullivan, 457 Laurel Street, Santa Cruz.
Solano County—President, Mrs. F. Burton Jones, P. O. Box 425, Vallejo.
Sonoma County—President, Mrs. D. C. Oakleaf, 704 West Street, Healdsburg.
Stanislaus County—President, Mrs. A. E. Ghilotti, 1815 Hintze Avenue, Modesto.
Tulare County—President, Mrs. George Keiper, 318 West School Street, Visalia.
Ventura County—President, Mrs. Walter F. Mosher, 2246 E. Main Street, Ventura.

Miscellaneous California Medical Organizations

Department of Public Health of the State of California

San Francisco—603 Pbelan Building, 760 Market Street, San Francisco; UNderhill 8700.
Sacramento—State Office Building, Tentb and L streets, CApital 2800.
Los Angeles—State Office Building, 217 West First Street. MAdison 1281.
President, Elmer Belt. Los Angeles.
Director, Bertram P. Brown, 603 Phelan Building, 760 Market Street, San Francisco.

California Northern District Medical Society

President—John H. Wbite, Chico.
Secretary—J. Homer Woolsey, Woodland Clinic, Woodland.

Board of Medical Examiners of the State of California

San Francisco, Rm. 214, 515 Van Ness Ave.
Los Angeles, 906 State Building.
Sacramento, Business and Proiessional Bldg., 1020 N Street.
President, Clark L. Abbott, Oakland.
Secretary, C. B. Pinkham. Room 214, 515 Van Ness Avenue, San Francisco.

Southern California Medical Association

President, Alvin Foord, 749 Fairmont Ave., Pasadena.
Secretary, Edward W. Boland. 2202 W. Third Street, Los Angeles.

The Public Health League of California

Executive Secretary, Ben H. Read, San Francisco office, 244 Kearny Street, phone SUtter 8470. Los Angeles office, Room 563, 1151 South Broadway, phone PRospect 5711.

Medical Schools of California

University of California Medical School, Third and Parnassus, San Francisco. Agnes L. Terry, Assistant to the Dean.
Stanford University School of Medicine, 2398 Sacramento Street, San Francisco. L. R. Chandler, M. D., Dean.
University of Southern California Medical School, 1100 N. Mission Road, Los Angeles. Paul S. McKibben, Sc. D., Dean.
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BOOK REVIEWS

BOOKS RECEIVED

Textbook of General Surgery. By Warren H. Cole, M. D., F.A.C.S., Professor and Head of the Department of Surgery, University of Illinois College of Medicine; Surgeon, Illinois Research Hospital, Chicago; and Robert Elman, M. D., Associate Professor of Clinical Surgery, Washington University School of Medicine; Assistant Surgeon, Barnes Hospital; Associate Surgeon, St. Louis Children's Hospital; Director of Surgical Service, H. G. Phillips Hospital, St. Louis. Cloth. Price, $8. Pp. 1067, with 558 illustrations. New York and London: D. Appleton-Century Company, 1941.

Cancer of the Face and Mouth: Diagnosis, Treatment, Surgical Repair. By Vilray P. Blair, M. D., Sherwood Moore, M. D., and Louis T. Byars, M. D. St. Louis. Cloth. Pp. 599, with 260 illustrations and 64 plates. St. Louis: The C. V. Mosby Company, 1941.

Immunity Against Animal Parasites. By James T. Culbertson, Assistant Professor of Bacteriology; College of Physicians and Surgeons; Columbia University. Cloth. Price, $3.50. Pp. 274. New York: Morningside Heights. Columbia University Press, 1941.

The 1941 Year Book of Public Health. Edited by J. C. Geiger, M. D., Dr. P. H., Director of Public Health, City and County of San Francisco; Clinical Professor of Epidemiology, University of California; Clinical Professor of Preventive Medicine and Public Health, Stanford University School of Medicine; Lecturer in Preventive Medi-

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BOOKS RECEIVED

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cine and Public Health, University of Southern California Medical School. Cloth. Pp. 544, with six illustrations. Chicago: The Year Book Publishers, Inc.

A Manual of Bandaging, Strapping, and Splinting. By Augustus Thorndike, Jr., M. D., F. A. C. S., Associate in Surgery, Harvard Medical School; Surgeon to the Department of Hygiene; Harvard University. Paper. Price, $1.50. Pp. 144, illustrated with 117 engravings. Philadelphia. Lea & Febiger, 1941.

Health Resorts of the USSR. A Symposium of Articles Compiled from Data of the Central Institute of Balneology in Moscow. Editor, Dr. I. A. Pertsov. Cloth. Pp. 269, with 44 illustrations. Moscow: The U. S. S. R. Society of Cultural Relations with Foreign Countries. (V. O. K. S.) 1941.

Life and Its Problems: As Viewed by a Blind Man at the Age of Ninety-Six. By Joseph P. Widney. Edited by T. Cameron Taylor. Cloth. Pp. 215. Hollywood: Joseph P. Widney Publications, 1941.

Synopsis of the Preparation and After-Care of Surgical Patients. By Hugh C. Ilgenfritz, A. B., M. D., Instructor in Surgery, Louisiana State University School of Medicine; Visiting Surgeon, Charity Hospital of Louisiana at New Orleans, and Rawley M. Penick, Jr., Ph. B., M. D., F. A. C. S., Professor of Clinical Surgery, Louisiana State University School of Medicine; Visiting Surgeon, Charity Hospital of Louisiana at New Orleans, with foreword by Urban Maes, M. D., D. Sc., F. A. C. S., Professor of Surgery and Director of the Department, Louisiana State University School of Medicine; Senior Visiting Surgeon, Charity Hospital of Louisiana at New Orleans; Consulting Surgeon, Touro Infirmary. Cloth. Pp. 532, with 55 illustrations. St. Louis: The C. V. Mosby Company, 1941.

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The Institute will augment the activities of National Posture Week through the creation and dissemination of additional material throughout the year.

It will cooperate in its work with members of the medical profession and other ethical groups; further, it will endeavor to impress upon the public not only the importance of good posture as it relates to good health, but will emphasize the desirability of periodic health examinations and professional medical counsel and guidance for special exercises and diets.

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BOOKS RECEIVED

(Continued from Page 8)

Telepathy: In Search of a Lost Faculty. By Eileen J. Garrett. With Introduction by Eugene Rollin Corson, B.S., M.D. Cloth. Price, $2.50. Pp. 210. New York: Creative Age Press, Inc., 1941.

The Art and Science of Nutrition: A Textbook on the Theory and Application of Nutrition. By Estelle E. Hawley, Ph. D., and Grace Carden, B. S., the University of Rochester, School of Medicine and Dentistry, Rochester, New York. Cloth. Pp. 619, with 140 illustrations, including 12 in color. St. Louis: The C. V. Mosby Company, 1941.

Professional Adjustments. I. By Gene Harrison, A. B., R. N., Educational Director, Druid City Hospital School of Nursing, Tuscaloosa, Alabama. Cloth. Pp. 204. St. Louis: The C. V. Mosby Company, 1941.

Dr. Colwell's Daily Log for Physicians. A Brief, Simple, Accurate Financial Record for the Physician's Desk. Paper. Price, $6. Champaign, Illinois. Colwell Publishing Company, 1941.

Gregg Medical Dictation Series: A Course for the Student Who Desires to Become Proficient in Taking Medical Dictation: Volume 6, Cardiology. By Marie Zweegman Yates, Director, Zweegman School for Medical Secretaries, San Francisco, California. Paper. Price, $1. Pp. 86. New York: The Gregg Publishing Company, 1941.

Gregg Medical Dictation Series: A Course for the Student Who Desires to Become Proficient in Taking Medical Dictation: Volume 7, Diseases of the Chest. By Marie Zweegman Yates, Director, Zweegman School for Medical Secretaries, San Francisco, California. Paper. Price, $1. Pp. 89. New York: The Gregg Publishing Company, 1941.

(Continued on Page 14)

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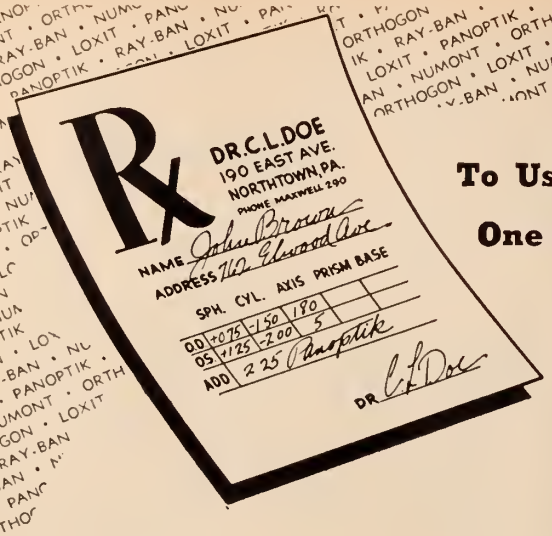

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BOOKS RECEIVED

(Continued from Page 10)

The Premature Infant: Its Medical and Nursing Care. By Julius H. Hess, M. D., Professor and Head of the Department of Pediatrics, University of Illinois College of Medicine; Attending Pediatrician, Illinois Research and Educational Hospital, Cook County and Michael Reese Hospitals, and Evelyn C. Lundeen, R. N., Supervisor, Premature Infant Station, Sarah Morris Hospital, Chicago. Cloth. Price, $3.50. Pp. 309, with 74 illustrations. Philadelphia: J. B. Lippincott Company, 1941.

BOOK REVIEWS

Textbook of General Surgery. By Warren H. Cole, M. D., F. A. C. S., Professor and Head of the Department of Surgery, University of Illinois College of Medicine; Surgeon, Illinois Research Hospital, Chicago; and Robert Elman, M. D., Associate Professor of Clinical Surgery, Washington University School of Medicine; Assistant Surgeon, Barnes Hospital; Associate Surgeon, St. Louis Children's Hospital; Director of Surgical Service, H. G. Phillips Hospital, St. Louis. Cloth. Price, $8. Pp. 1067, with 558 illustrations. New York and London: D. Appleton-Century Company, 1941.

The most important aspects of surgery have been covered in this new edition. Of necessity, to embrace the subject in one volume, conciseness has had to govern. This has led to the omission of some material at times of importance. In spite of this, the treatment of the majority of subjects is very good, the text is readable, and the illustrations do what they purport—illustrate. A good working bibliography has been appended at the end of each section.

The volume is carefully prepared and has an excellent index. It should be received well, not only by students and general practitioners, but found useful by experienced surgeons.—G.

The Therapy of the Neuroses and Psychoses. A Socio-Psycho-Biologic Analysis and Resynthesis. By Samuel Henry Kraines, M. D., Associate in Psychiatry, Uni-

(Continued on Page 16)

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[1] Jeffcoate, T. N. A.: *Brit. Med. J.* 2:671 (Sept. 30) 1939.

For literature address the Professional Service Department, E. R. Squibb & Sons, 745 Fifth Avenue, New York, N. Y.

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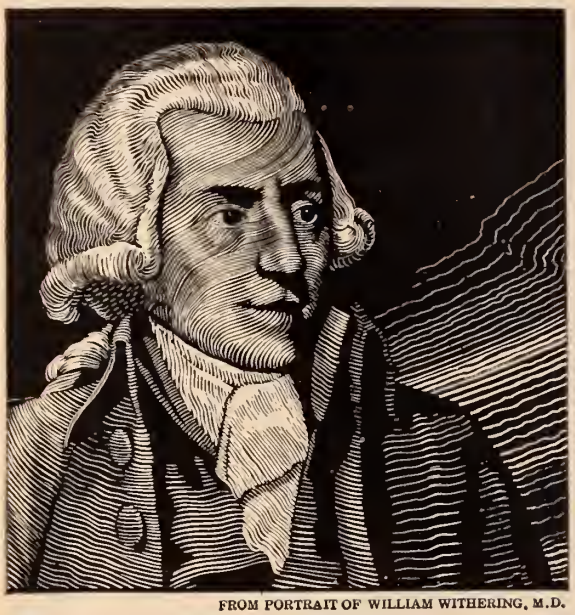

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BOOK REVIEWS

(Continued from Page 14)

versity of Illinois, College of Medicine; Assistant State Alienist, State of Illinois; Diplomate of American Board of Psychiatry and Neurology. Cloth. Pp. 512. Price, $5.50. Philadelphia: Lea & Febiger, 1941.

The chapters on "The Fundamental Psychology of the Psychoneuroses," "Psychoneurotic Symptoms Expressed Primarily by Psychologic Factors," "Psychoneurotic (Tension) Symptoms Due to Disturbances in the Autonomic Nervous System," and the chapter on "The Principles of Psychotherapy" make the book well worth while.

The book is especially valuable, as the author is not a cultist but treats the neuroses and the psychoses on the basis of organismal unity.

The "Therapy of the Neuroses and Psychoses" is indeed valuable, both for the specialist in neuropsychiatry and for the general practitioner.—Rossner E. Graham, M. D.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 278)

Important Notice: Scientific Program.—The members of the Scientific Program Committee wish to again call the attention of the members of the State Society to the absolute necessity of making early application for places on the program. They again call attention to the ruling that not only must titles to papers be in the hands of the Program Committee before January, but each author must furnish by that date a synopsis of the paper to be read. These titles and synopses will be published in the JOURNAL before the April meeting. This ruling was made in order to furnish an opportunity for those wishing to take part in discussions to be informed in advance regarding the particular phases of a problem which the author intends to treat in the presentation of his paper. It is felt that only in

(Continued on Page 18)

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TWENTY-FIVE YEARS AGO

(Continued from Page 16)

this way can the greatest good be obtained from discussion.

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State Pasteurization of Milk.—On October 1, [1916] the state law relative to pasteurization of milk went into effect. Some movement of this kind has been needed for a long time, for while it has been possible in the larger cities to demand and secure a fairly clean milk, it has not been possible to do so in the smaller communities. . . .

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(Continued on Page 20)

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(3) The total caloric value of the formula should be approximately 50 to 55 calories per pound (110 to 115 calories per kilo) of body weight per day.

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KUGELMASS: "*Newer Nutrition in Pediatric Practice.*" 1940.

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TWENTY-FIVE YEARS AGO

(Continued from Page 18)

in its clinics and laboratories? Is its mission ended with the charitable work of its hospital and clinic and with its activities in the field of hygiene and preventive medicine? Is not the university as a state school overlooking an important field of endeavor to which its facilities can be readily adapted? . . .

Philip Mills Jones, Attorney.—The legal difficulties and troubles of the many members of the Society took up so much time of the Secretary of the Medical Society of the State of California, and it was difficult to get lawyers to understand medicine, that the Secretary had to study law, and on October 19, 1916, passed the Bar Examination and was admitted to practice as an attorney and counselor at law, in all the courts of the State.

Medical Preparedness.—A course of lectures on medical preparedness is being given in the Library of the San Francisco County Medical Society every Thursday afternoon at 5 p. m. by the Army, Navy and Public Health Services. . . .

EXCERPTS FROM MISCELLANEOUS ARTICLES

From an Article on "Should the Medical Profession Plead in Favor of the Proposed Health Insurance Bill?" by John H. Graves, M. D., San Francisco.—Before the medical profession can intelligently support any proposition for Health Insurance, it will be necessary first for the proponents of the measure to agree among themselves as to the character of the law and to present clearly their conclusions on the following points:

1. Is any law of this character necessary to the welfare of the people of the State of California?

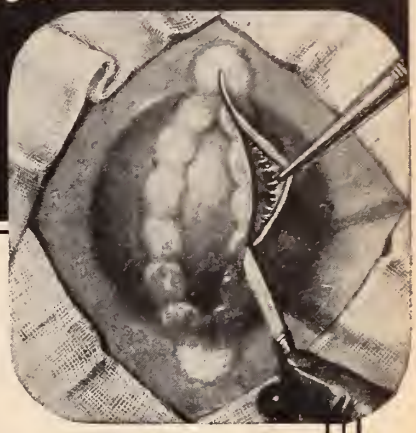
2. Will the measure be so framed that those who come under the provisions of the act be entirely free to choose their own medical attendants, or will they be compelled, as they now are under the Workmen's Compensation Act, to accept the services of cut-rate physicians, selected by insurance companies?

3. Are the people who are supposed to be benefited by this law desirous of the passage of such a measure?

4. Will the present high standard of medical service rendered to the people of the State be lowered by such a law as it has admittedly been lowered by the passing of the Workmen's Compensation Act; and what effect will the proposed measure have on the doctor's income?

(Continued on Page 22)

Time-tested dependable LOCAL ANESTHETIC



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TWENTY-FIVE YEARS AGO

(Continued from Page 20)

5. Can the proponents of the measure after they have agreed among themselves, if that be possible, give any assurance that the measure, as presented to the Legislature, will be accepted and made into law without amendments, which would entirely change any or all of the provisions?

I am quoting the opinion and authority of men who have lived among California conditions and studied California subjects from every angle and who have investigated status of life in Europe and Asia and the attempts of the governments of those countries to solve their weighty problems of overbearing poverty. No European sociologist is as competent to judge what is best for California as the man who has lived in and intelligently studied the welfare of the State. . . .

Discussion:

Dr. A. S. Keenan: Just to keep the subject bubbling, it would interest me to know why we should make a radical change in the present condition. I am inclined to agree with Doctor Graves' paper. The large middle class—are they getting such poor attention? It is not always necessary that every patient should get the very best doctor. In the legal profession you do not need the best lawyer when you want to get a divorce. It is not necessary to have the very best surgeon or physician for an ordinary complaint. You get a man you can afford to pay, and his knowledge and experience is sufficient to carry you on.

Dr. Morton R. Gibbons: I made the statement that the average surgical work in California since the workmen's compensation act went into effect had been less satisfactory

(Continued on Page 24)

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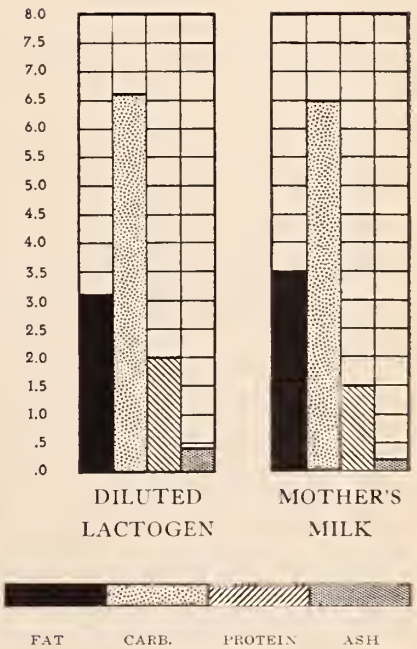

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JOHN LOVETT MORSE, A. M., M. D.
Clinical Pediatrics, p. 156

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TWENTY-FIVE YEARS AGO

(Continued from Page 22)

than before, in my opinion. My explanation was that whereas before the law went into effect, the major part of that surgery was done by county hospitals, and the service was from average to excellent. Now, because of the provisions of the law, it has fallen into the hands of individuals who do that work simply because there is a fee in it, and have not the requisite skill nor experience.

Doctor Graves, closing: I want to state first that I am inclined to believe that the chief object of writing my feeble paper has been accomplished, for it was this: to stimulate members of the medical profession, and especially those who are actually practicing medicine—not men who are interested in other things, all kinds of governmental and social problems—to take an active interest in this important thing. If you do not take care of yourselves you will be hindmost. If I have stimulated a little interest among you busy men, I have accomplished something worth while, I hope. . . .

From an Article on "The Proposed Social Health Insurance Act," by Donald M. Gedge, San Francisco.—On Tuesday, September 12, 1916, personally appeared before the County Medical Society of San Francisco, Dr. J. L. Whitney, who delivered a paper on "Coöperative Medicine to Social Insurance," and Dr. J. M. Rubinow, consulting actuary to the Social Insurance Commission of California, who read a paper on "The Judicious Attitude Toward Health Insurance."

Such a feast of theoretical and fantastical viands has seldom been offered to the medical fraternity of California; and, were it not for the evident earnestness of

(Continued on Page 26)

An Effective Medicinal Weapon Against Depressions

Mild pathological depressions may accompany a variety of clinical syndromes. In addition to prescribing whatever forms of therapy are indicated for the individual condition, it may also be advisable to treat the underlying or concomitant depression.

If, in the judgment of the physician, treatment of this depression appears advisable, the administration of Benzedrine Sulfate Tablets will often prove useful. In depressive psychopathic cases the patient should be institutionalized.

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TWENTY-FIVE YEARS AGO

(Continued from Page 24)

those who delivered it, indignation would certainly have added to the violent mental indigestion that overwhelmed the doctors present. To be sure we appreciate the paternal and eleemosynary fantasy that is now sweeping over the land. Inconsistency and absurd theories have no longer found a place in European fields, where the unfortunate people are engaged in more portentous things; so the bacillus prodigeosis of socialistic vagarics has been transported to America, where it, apparently, is finding a pabulum upon which to glut its voracious appetite. The probabilities and possibilities of a social insurance plan against sickness, etc., as outlined by Doctor Whitney in his able dissertation, are quite admissible; but the *raison d'etre* is another question. Exploitation of academic questions by an academician is always of interest and duly convincing, provided an admissible syllogism obtains with a rational premise. In this instance we are not willing to admit Doctor Whitney established any such tenable position. . . .

From an Article on "Upon the Sero-Diagnosis of Gonorrhea," by Martin Krotoszyner, M. D., San Francisco.—The most epoch making event in the history of syphilis, is, undoubtedly, the application of the reaction for its diagnosis by Wassermann, which, at present, is justly considered a success. About ten years ago Müller and Oppenheim began to utilize the same reaction, in a similar manner, for the diagnosis of gonorrhea. To American investigators, Teague and Torrey and especially to Schwartz and McNeill, who were the first to use a polyvalent gonorrheal

(Continued in Back Advertising Section, Page 30)

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CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

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G. W. Walker.....Fresno 1943
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Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number see index below.)

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Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

MEDICAL PREPAREDNESS: MILITARY; CIVILIAN; RED CROSS

United States Has the Lowest Morbidity and Mortality Rates.—Morbidity and mortality rates in the United States for years have been lower than those of any European or other nation. Therefore it may be taken, as a sound conclusion, to affirm that the "preparedness" of physicians in the United States is of a high standard, because otherwise such statistics would not obtain, since climatic, industrial, and various conditions here are not greatly superior to those of other lands.

The above comment relates to what has been accomplished in days of peace by the American medical profession in the preventive and healing activities of medicine. The record may be taken as a token of what still may be expected from physicians in times of emergency or war—whichever term may be the more appropriate under existing conditions.

* * *

Effect of Selective Service Act on Private Medical Practice.—When Congress passed the Selective Service Act to bring into somewhat sudden being an army of 1,400,000 men, as provided in the Selective Service Act, it was certain that there would follow important results to civilian medical practice. For at once, step by step, as the induction of men as soldiers took place, there was also necessitated the induction of medical officers and personnel to look after the physical and mental well-being of those soldiers.

A few years ago, the massiveness of the present military set-up of the United States was not a subject of contemplation by the great majority of citizens, physicians included. However, an emergency has arisen that has been as great a surprise to physicians as to others.

For many medical men the new conditions meant a radical rearrangement of preëxisting plans of professional life and activities. Yet, in spite of this, the medical profession has not been found wanting. Through their national, state and county organizations, and also as individuals, doctors of medicine have met the call that has come to them. Those who have been inducted into service are now busily engaged in acquainting themselves with their new duties, even though existing military

†Editorials on subjects of scientific and editorial interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

routine, to many of them, is far distant from the busy professional lives that until recently were part of their daily living and responsibilities.

* * *

American Medical Association Met Its Responsibilities.—When the present emergency arose, far-sighted leaders in the American Medical Association—many of who had seen active service in Word War I—were quick to appreciate that the general staffs of the military forces of the Union were not in possession of the information that would permit them to proceed in a big way to place medical men who were to be inducted into service into places where each could be of greatest service. In this emergency the American Medical Association, through an expenditure of some $50,000 of its own funds, voluntarily gathered the needed information concerning physicians and made the same available to the Government! This was a great service, not yet appreciated by the people at large.

The medical profession, as a fact, has fully cooperated, not only in using its best efforts to provide medical staffs for the Army and Navy, but in having its members give a tremendous amount of gratuitous service as volunteer examiners for the local Selective Service Boards.

* * *

Obligations of Organized Medicine in Local Communities.—Organized medicine, through the state and component county societies, may take a justifiable pride in the record of service so well rendered by its members, but these organizations have an additional obligation to physicians who have been inducted into service, and whose personal and financial arrangements have received, in many cases, distinct shocks. That is why the California Medical Association will excuse military members from payment of State Association dues, and why component county societies, which have not yet taken similar action, should consider such action. It would be gratifying, indeed, if it could be stated that each of the forty component county units comprising the California Medical Association had made such provision.

Of course, the full story has not yet been told, and it is possible—should certain events arise in the international world—that still further changes and inductions into military service may be necessary. It is well for all to keep this possibility in mind.

* * *

A New Activity: "Civilian Defense."—At the time the Selective Service Act became operative, and more and more physicians were laying the obligations of private practice aside, attention was called to the increased responsibilities of those physicians who would remain behind, and upon whom must devolve the care of the civilian population. Special stress was placed upon the importance of maintaining, in good health, men and women who were engaged in the so-called essential industries—those from which the supplies were to be secured that would permit Army and Navy to function with greatest efficiency. The importance of proper care of these civilians was emphasized, since the maintenance of morale of soldiers, in camp or at the front, will depend, in considerable degree, upon freedom of worry concerning folks left at home.

Since then, by announcement from the President of the United States, the "Office of Civilian Defense" has been brought into being, with Mayor F. H. La Guardia of New York City as "U. S. Director, Civilian Defense," in charge.*

That newly created department of the National Government aims to bring into operation civilian forces which will be of aid in case our country becomes actually engaged in war. In the October issue of CALIFORNIA AND WESTERN MEDICINE, on page 207, comment was made concerning the national and regional offices of this activity, which has offices in Washington, D. C., and also for this regional area (one and the same as the Ninth Army Corps Area) in San Francisco.

Californians who are interested should write to the Ninth Civilian Area at 233 Sansome Street, San Francisco (Wallace Hunt, M. D., in charge), for further information in regard to Civilian Defense plans.

* * *

American Red Cross and Civilian Defense.—Physicians and others who are interested in American Red Cross activities are requested to refer to the communications in this number of the OFFICIAL JOURNAL, which are given on page 276, in which an official announcement appears delineating the scope of the respective activities: "Office of Civilian Defense" and "American Red Cross." A perusal of the letters there appearing will enable physicians to orient themselves and be able to give more accurate information.

FEDERAL REHABILITATION PROGRAM: HOW FAR WILL IT GO?

President Roosevelt's Pronouncement.—Under the alluring caption, "Army to Salvage 200,000 Men," Washington press dispatches have told us that President Franklin Delano Roosevelt had announced a plan to "salvage the equivalent of thirteen divisions of troops by curing physical defects of 200,000 rejected draftees." The Associated Press item of October 10 stated further:

> At his press conference the President said that figures from General Louis B. Hershey, director of selective service, showed that 900,000 of the first two million men examined were found to be physically or mentally unfit.
>
> Of this number it is estimated that 200,000 can be made fit for full active duty. Of the remainder, it is estimated that more than half can be restored to health sufficient to enable them to perform limited military service. Others suffering from mental, nervous, heart and lung diseases and muscular-skeletal diseases will not be considered for any type of Army duty, the President declared.
>
> One hundred thousand of the rejected men were turned down because they lacked the equivalent of a fourth grade education. This problem, he said, was primarily a state and local one.
>
> As for the health rehabilitation program, present plans call for the men to be treated by their local physicians and dentists, who would be paid by the Federal Government at rates to be set by the American Medical Association and the American Dental Association.

* In Letters department, in this issue, see communications on page 276.

Data From World War I.—The information contained in the above should have a real appeal to physicians, for it is to be hoped that the sentiments so well expressed will be carried through to fruition. The basic facts concerning physical deficiencies of a large proportion of Americans have been well known to physicians, the data having been of special record in connection with medical examinations made during World War I. However, when that struggle came to an end, all the emotional disturbance arising from such disturbing medical statistics promptly subsided; the governing authorities in federal and state legislation activities then promptly turning their attention to matters of immediate political importance and expediency.

To remind ourselves, let us glance at some of the World War I and present-day Selective Service figures since, certainly, to physicians, at least, they have particular interest:

Kimball detailed the causes of rejection for the 1918 draft as follows:

Causes for Disqualification	*Percentage*
1. Skin and teeth	3
2. Unclassified defects, including respiratory diseases, other than tuberculosis	4
3. Nose and throat, including bad tonsils, sinus trouble, hay fever, etc.	5
4. Tuberculosis of bone or lungs	5
5. Venereal diseases, *i.e.*, syphilis or gonorrhea	5
6. Nervous and mental, including St. Vitus dance, as well as mental deficiencies	6
7. Glandular defects in various glands, resulting in underweight in half of the cases, underheight, curvature of spine, and goiter	10
8. Cardiovascular diseases and defects affecting heart or blood vessels	10
9. Sense organs, one-half in the eye, one-half in hearing, speech, etc.	12
10. Mechanical defects in bony structure of body, resulting in weak joints, hands, or feet (Weak or flat feet were by far the most important)	40
	100

"In 1918, 486 out of every 1,000 men examined were rejected, which is 48.6 per cent.

* * *

Selective Service Statistics of 1940.—As of even date with President Roosevelt's rehabilitation pronouncement, United Press dispatches gave statistics, submitted by Brigadier General Lewis B. Hershey, Director of Selective Service—who analyzed the causes of 1940 rejections—as follows:

Causes of Disqualification	*Percentage*
a. Dental defects, 188,000 cases	20.9
b. Defective eyes, 123,000 cases	13.7
c. Cardiovascular diseases, 96,000 cases	10.6
d. Musculoskeletal defects, 61,000 cases	6.8
e. Venereal cases, 57,000	6.3
f. Mental and nervous diseases, 57,000 cases	6.3
g. Hernia, 56,000 cases	6.2
h. Defects of ears, 41,000 cases	4.6
i. Defects of feet, 36,000 cases	4.0
j. Defective lungs, including tuberculosis, 26,000 cases	2.9
k. Miscellaneous, 159,000 cases	17.7

How Government Proposes to Proceed.—Director of Selective Service General Hershey, stated further:

"The registrant will have the privilege of having the services performed by his family physician or dentist in his own community.

"The cost of this rehabilitation program will be borne by the Federal Government as a necessary part of our national defense program, and additional funds will be made available to the selective service system for this purpose."

President Roosevelt disclosed that plans already are well advanced for the salvage program. In cases of heart and musculoskeletal diseases, as well as mental and nervous cases, persons considered by local boards as being susceptible to rehabilitation will be placed in a special selective service category.

Remaining under orders of their selection boards, these men then will be visited by traveling boards or "teams" of outstanding specialists, who will examine them and recommend curable cases for immediate treatment at Government cost.

* * *

Gratuitous "Examination" Work Should Not Include "Treatment."—All the above is most interesting, especially to members of the medical profession.

In this connection, however, it may not be amiss to refer to the last annual session of the California Medical Association, at which one of the military representatives, only recently inducted from civil practice, took occasion in his paper to criticize members of the medical profession for not more generously going into service. At a subsequent club meeting, at which the same speaker criticized volunteer medical examiners for not removing hard wax plugs from ears, etc., his attention was called to the fact that medical examiners on Selective Service Boards had volunteered to examine selectees, and that an examination was not synonymous with treatment.

Mention is made of this to bring out the point that it should not be a matter of surprise when lay persons become confused concerning the fields of diagnosis and treatment, since medical graduates themselves sometimes commit a similar error.

* * *

No "Below-Cost Fee Tables" Should Be Sanctioned.—Following the original dispatches referred to above, no news items concerning the basis of remuneration for the rehabilitation treatments, so prominently publicized, have been noted. So again the hope may be expressed that the medical profession will not continue to commit one of its egregious errors by announcing and publicizing fee tables with rates far below those of established custom; and such as have been found to be necessary if the physician is to maintain himself and his family in proper station, and be fitted to carry on the responsibilities constantly confronting him in his work.

Almost every day, in the press, statements are given, with more or less praise, that this, that, or some other major manufacturing or construction organization will do certain work at cost, plus only 10 per cent. Labor, also, through its organized agencies, seeks always to keep the incomes of its members in harmony with rising costs. Physicians, however, by contrast, are prone to promulgate fee

tables for services which fail to take into account office rent, clerical aid and other phases of upkeep. In every such instance, a fee table is given publicity that leads many former and prospective patients to believe that the fees requested from them later on are exorbitant. The reward for overgenerous action is, therefore, not good-, but ill-will.

It is true that in emergencies confronting our country we should give without stint. It is not necessary, however, for physicians, by way of example, to compensate themselves at less than cost values, to the detriment, not only of their to-days, but of the days to come. Meaning, when transposed, nothing more nor less than this, that if the Federal and State Governments wish to subsidize rehabilitation work for selectees who have been rejected because of physical defects, the compensation to physicians should be adequate; that is, of amount to cover all costs involved, plus that small margin of net return that will permit the physician or surgeon to have at least a moderate compensation for his endeavors to make a citizen having defects again efficient to his country, from both the "utilitarian" and a "military" aspects.

HOSPITAL SERVICE INSURANCE: A STATEMENT OF C. M. A. POLICY

Action of the Council of the California Medical Association.—In this issue, on page 255, are given the minutes of the 296th meeting of the California Medical Association Council, held in Los Angeles on October 26, 1941. It is to be hoped that the account of the proceedings will be read, not only by the officers of component county societies, but that most of the members will also take the time to scan them, since matters of importance concerning both scientific and organized medicine appear therein.

* * *

Text of the "Statement of Policy."—Of special interest to members of the California Medical Association is Item 9 of the minutes, on page 256, with its presentation of the conditions laid down by the California Medical Association for observance by hospital service organizations, before their policies or contracts may be given approval.

Request is made that members read this statement, since its proper execution implies the full coöperation of all concerned. Statement follows:

"HOSPITAL SERVICE INSURANCE

"A Statement of Policy issued by the California Medical Association, October 26, 1941

"The California Medical Association has consistently endorsed the principle of hospital service insurance and, upon request, the Council of the California Medical Association has given its approval to some or all of the activities of local hospitalization associations. The California Medical Association recommends only those hospital contracts which provide straight hospital services. It does not give, and it never has given approval to any contracts which provide medical benefits or services as a part of hospital services. It does not object to the provisions of limited diagnostic medical services (x-ray and laboratory) along with hospital benefits, provided that these are arranged for on some ethical and legal basis, such as reimbursement or indemnification. The following points are therefore emphasized:

"1. The California Medical Association approves hospital service insurance associations which issue straight hospital service policies (for example: the hospital contract issued by Hospital Service of California and the Associated Hospital Service of Southern California in conjunction with California Physicians' Service).

"2. It does not recommend any hospitalization contract which provides diagnostic x-ray, laboratory or other medical services as hospital benefits. These are medical benefits and may only be issued on an indemnification or medical service basis.

"3. When hospital service insurance associations issue hospital service contracts which include indemnification for diagnostic medical services, it is desirable that such be specified in the description of the contract (for example: Hospital service contract and limited professional service contract). Further, it is desirable that the association issuing such contracts make specific arrangements whereby the fees for radiology or pathology are payable to the physician rendering those services, or jointly to the physician and subscriber (in which case the subscriber can endorse the check over to the physician rendering the service). In this manner the hospitalization association will be complying with the letter as well as the spirit of indemnification.

"4. The California Medical Association emphasizes that it does not approve or endorse any hospital service contracts which purport to provide any medical services as a part of hospital services, nor can it countenance the issuance by any hospitalization association of advertising literature which does not indicate that payment for medical services is being made to physicians rendering such services. It is important for the welfare of the public, the hospitals and the medical profession that a clear distinction be made between hospital service and medical service in any and all of these hospitalization insurance contracts."

SOME REMARKABLE LETTERS: INVOLVING THE CALIFORNIA STATE COMPENSATION INSURANCE FUND

Council's Consideration of the Letters, and Decisions Thereon.—On October 26, the Council of the California Medical Association held its quarterly meeting in Los Angeles. The minutes of the proceedings appear in this number of the OFFICIAL JOURNAL. The Council voted that the attention of members be specifically called in the editorial department to *Item 11—California State*

Compensation Insurance Fund: Some Testimonial Correspondence (see page 257), and to letters submitted therewith.

The action taken by the Council, as given in Item 11, is indicated in the following:

(Copy)

"CALIFORNIA STATE COMPENSATION INSURANCE FUND: SOME TESTIMONIAL CORRESPONDENCE

"(*a*) *Presentation of Copies of Certain Letters.* The attention of the Council was called to certain communications that had been circularized to members of the medical profession by the Wilshire Medical Laboratories of Los Angeles, as follows:

"(1) A photostatic copy of a letter bearing the signature of John C. Stirrat, manager of the State Compensation Insurance Fund; and

"(2) An appeal that laboratory work needed for injured employees be sent to said laboratory.

"After consideration of the same and other evidence, upon motion duly made and seconded, it was voted that the Council agreed that the Manager of the State Compensation Insurance Fund has exhibited unwarranted favoritism in favor of said laboratory, thus discriminating against many equally or better qualified laboratories.

"Further, the Council of the California Medical Association considers compliance with the suggestions contained in the photostatic copy of the letter dated August 22, 1941, and signed by the Manager of the State Compensation Insurance Fund, to be beneath the dignity of the members of the California Medical Association.

"The Council also expresses its unqualified disapproval of this campaign of solicitation by a state official on behalf of a private institution, ignoring as he has done, many competent, medically directed laboratories in Los Angeles and vicinity, in addition to the attempted use of political influence in relation to the medical care of the unfortunate victims of industrial accidents.

"(*b*) *Instructions to Executive Committee to Call Attention of Certain State Officials to Pertinent Correspondence.*—After further discussion, on motion duly made and seconded it was voted that the Executive Committee be directed by the Council, within fourteen days, to formulate a protest embodying the sentiments included in the aforesaid resolutions, and as brought out in the discussion on the evidence presented; and that copies of such protest be forwarded to His Excellency, Governor Culbert Olson, Mr. John C. Stirrat, manager of the State Compensation Insurance Fund, the Industrial Accident Commission, the State Compensation Insurance Fund, and other interested State agencies, such protest to have attached copies of the photostat letters bearing the signature of Mr. Stirrat, and the two enclosures from the Wilshire Medical Laboratories; and further, that the action taken by the Council be published in the editorial section of the next issue of CALIFORNIA AND WESTERN MEDICINE.

Letters referred to above, follow:

(Copy: Letter No. 1)

(COPY OF PHOTOSTAT)

WILSHIRE MEDICAL LABORATORIES
X-RAY AND CLINICAL
2016 Wilshire Boulevard, Los Angeles, California
Telephone DRexel 1235

August 29, 1941.

Dear Doctor:

Enclosed please find photostatic copy of letter to us from Mr. John C. Stirrat, Manager of the State Compensation Insurance Fund, which is self-explanatory. In order that you may be enabled to conform to his request, we are enclosing blanks for referring patients of the State Fund to us.

We are also enclosing Doctor's Fee schedule for both x-ray and clinical laboratory procedures which would apply to your private practice, in the event you desire to refer this work to us in addition to the State Fund's x-ray and clinical laboratory examinations.

We wish to assure you of efficient and prompt service on your requests in State Fund cases, conforming to the photostatic copy of Mr. Stirrat's letter herewith. We also hope to merit your confidence to the extent that you will refer to us your private x-ray and clinical laboratory examinations.

Very truly yours,

WILSHIRE MEDICAL LABORATORIES,
(Signed) MAC C. SANDLER,
By Mac C. Sandler, M. T.,
Executive Director.

(Signed) F. ALFRED BLATZ,
By F. Alfred Blatz,
M.S./ebg *Public Relations Consultant.*

* * *

(Copy: Letter No. 2)

(COPY)

WILSHIRE MEDICAL LABORATORIES
2016 Wilshire Boulevard, Los Angeles, California
Telephone DRexel 1235

September 27, 1941.

Dear Doctor:

It is our understanding that you are always interested in current news and up to the minute developments in modern medicine and important factors in connection therewith.

We therefore feel that you will be interested in the enclosed photostatic copy of a letter recently received by us.

The State Compensation Insurance Fund is thoroughly convinced of the quality of the Clinical and X-Ray procedures developed in this Laboratory, Doctor, and it is our earnest desire that you will share that confidence with them whenever you require professional laboratory assistance.

We shall welcome each opportunity to serve you and assure you that every effort will be made to merit the confidence you place in us.

Very truly yours,

WILSHIRE MEDICAL LABORATORIES,
(Signed) MAC C. SANDLER,
By Mac C. Sandler, M. T.,
Executive Director.

(Signed) F. ALFRED BLATZ,
Encl. s. By F. Alfred Blatz,
MCS/fg *Public Relations Consultant.*

(Copy: Letter No. 3)

(COPY OF PHOTOSTAT)

CULBERT L. OLSON, GOVERNOR

STATE COMPENSATION INSURANCE FUND

Executive Offices San Francisco

John C. Stirrat, Manager
J. J. Gallagher, Secretary
H. C. Miller, Comptroller

L. I. Newman, M. D., Medical Director
Donald Gallagher, Counsel

(SEAL)

Los Angeles, Oakland, Sacramento, Fresno, San Diego, Stockton, San Jose, Long Beach, Santa Barbara
450 McAllister Street, San Francisco

In Reply Please Mention

August 22, 1941.

Wilshire Medical Laboratories
2016 Wilshire Boulevard
Los Angeles, California

Gentlemen:

The qualifications and abilities of your personnel have been brought to my attention. Dr. Leighton Cornman, your Medical Director and Roentgenologist, has an exceptionally fine and valuable background in his specialty. The publications of which L. M. Hussey, Ph. D., your Technical Director, is the author, bespeak for his great ability as a biochemist and bacteriologist. With Dr. I. Singerman in charge of Electrocardiogram delineation together with the balance of its able staff, the Wilshire Medical Laboratories are thoroughly competent and well qualified to handle any x-ray and clinical laboratory work whatsoever.

The State Compensation Insurance Fund, as a matter of policy, has not directed where the physicians and surgeons to whom it has occasion to refer medical work should refer such x-ray and clinical laboratory work which may be required on its cases and which such doctors may not be equipped to handle personally. However, it certainly would gratify and please me very much if each of such doctors would refer such x-ray and clinical laboratory work as may be required on State Fund cases, which they are unable to perform personally, to the Wilshire Medical Laboratories.

You are at liberty to quote me concerning this expression of my confidence in the work performed by your laboratories.

Very truly yours,

(Signed) JOHN C. STIRRAT,
Manager.

JCS:LH

Created by the State of California to furnish protection to Employers at the lowest possible cost and to guarantee to their Employees all the benefits to which they are entitled.

C. M. A. ACTIVITIES: POSTGRADUATE; ANNUAL SESSION; PUBLIC HEALTH EXHIBITS AT COUNTY FAIRS

Postgraduate Conferences and Refresher Courses.—Any activity, if it has not reached its fullest capacity for service, is worthy of repeated mention. That is why the work of the California Medical Association Committee on Postgraduate Activities is so often called to the attention of component county societies. If the California Medical Association seems to have been laggard in this work, it is proper to state that it is only having the experience of many other state medical societies. Physicians everywhere acknowledge the importance of keeping in touch with changing procedures and newer methods in diagnosis and treatment. Their noncoöperation in regard to refresher and after-graduation courses is not due, therefore, to any lack of recognition of the need of such work. The explanation is to be found, rather, in the demands of private practice and patients, that nothing shall interfere with the attendance of the physician if he be within call at a time when indisposition or illness manifests itself.

A limited number of physicians have learned, however, that attendance at follow-up and post- or after-graduation courses is the better policy in the long run, because whatever makes for a better quality of service, also, in time, promotes a larger and a more lucrative clientele. However, the alert physician, no matter what his year or place of graduation, will always, for his own sake, seek to add to his store of professional knowledge so that he may be able, in turn, to give far more efficient service. By so doing, the outlook of a youthful mind is best promoted.

Wherefore, if your county society has not yet appointed a postgraduate committee, you are again urged to sponsor such a movement. The California Medical Association Postgraduate Committee, through the Association Secretary, will be happy to send supplementary information to local committees, and to be of all possible aid in giving publicity to refresher and other programs.

* * *

Annual Session: Del Monte, May 4-7, 1942.—Time flies, and next year's annual session will be at hand, almost before most of us are aware. Members who are in position to submit papers for the program are again reminded to promptly communicate with the proper Section Secretary.* Physicians who are in position, also, to present scientific exhibits or medical films, are requested to write to the Association Secretary at 450 Sutter, San Francisco, for further information.

* * *

Public Health Exhibits at County Fairs.—In spite of a late start, the effort to present public health exhibits at county fairs was carried through during this first year's endeavor with more success than had been anticipated. Hence, it is gratifying to know that the members of local committees, under whose auspices some sixteen exhibits were presented, were all favorably impressed with the value of this important publicity medium. In order to make possible a presentation of this activity on a much larger scale at next year's fairs, every county society is urged to promptly appoint its committees; for the California Medical Association Committee on Public Health Education will greatly appreciate such coöperation.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 255.

* Names and addresses of section officers appear on advertising page 6 of CALIFORNIA AND WESTERN MEDICINE.

EDITORIAL COMMENT†

VIRUS AGGLUTINATION

Successful applications of the new technique of specific agglutination of virus-coated bacteria are currently reported by Roberts and Jones [1] of the Department of Bacteriology, St. Louis University. Data thus far published by the St. Louis investigators suggest that the new technique may be of wide clinical application and may necessitate numerous revisions of basic concepts in many fields of practical diagnosis and therapy.

About fifteen years ago it was shown by Freund,[2] and has been subsequently confirmed by other investigators,[3] that if a soluble protein is adsorbed on the surfaces of small particles, the coated particles are readily agglutinated with the antiserums of animals immunized against this protein. Collodion particles were used by the earlier investigators. Jones,[3] however, found that certain nonpathogenic bacteria are more readily coated by alien proteins, heat-killed B. prodigiosus, for example, being successfully coated with horse or beef proteins by mere incubation in the presence of horse or beef serum. After thorough washing with saline solution, the exposed bacterial cells can be agglutinated by minute traces of homologous rabbit precipitins.

Quantitative comparisons showed that the agglutination test is at least one hundred times more delicate than the routine precipitin test with the same protein. In a rabbit injected with a single subcutaneous dose of 0.1 cubic centimeter of horse serum per kilogram of body weight, for example, the routine precipitin test shows no trace of specific antibody formation till the fourth day. Using a suspension of horse-protein coated B. prodigiosus as the diagnostic agent, however, specific antibody formation may be demonstrable as early as twenty-four hours, the titer rising to a maximum by the fourth day. After this, there is a precipitous fall in titer, antibodies, however, being demonstrable for many weeks after their apparent complete disappearance as shown by the conventional precipitin reaction. Applying this new diagnostic reagent to human beings who had received antigenic foreign proteins, Roberts and Jones found that in man also antibodies can be detected much earlier than currently assumed and that they present in significant amounts much longer than now believed.

Since the new agglutination technique is capable of detecting antibodies in quantities too small to be revealed by routine methods, there is a suggested necessity of an experimental restudy of many fields of clinical immunology. Applying the new technique to a study of St. Louis type encephalitis, for example, Roberts and Jones found B. prodigiosus could be effectively coated with the virus by incubating the heat-killed microörganisms in a saline emulsion of infected mouse brain. That the virus was actually adsorbed on the bacteria was indicated by the observation that after repeated washings with saline solution, such coated cells will reproduce typical encephalitis upon intranasal implantation in mice.

Suspensions of encephalitis-coated bacteria were used as diagnostic antigens. Rabbits repeatedly injected with encephalitis brain suspensions yielded antisera which agglutinated the virus-coated bacteria in dilutions as high as 1:512, control tests with the serum of normal rabbits and of rabbits immunized against normal mouse brain, giving negative results. In convalescent human beings the same specific agglutination reaction occurred in dilutions as high as 1:128. Eighty per cent of all supposedly normal individuals gave positive reaction usually in dilutions higher than 1:8. In most, but not all, instances the agglutinin titer is correlated with the viricidal index. Experiments are now under way to apply the same technique to poliomyelitis and to other conditions in which low titer antibodies conceivably play an important clinical rôle. Applications to allergy, to the toxemia of pregnancy, and to malignant diseases will be awaited with interest.

P. O. Box 51.

W. H. Manwaring,
Stanford University.

MENSTRUAL TOXIN

Demonstration of a highly toxic euglobulin in menstrual discharge is an interesting confirmation of a popular medical belief.

In order to study the physiological properties of the menstrual flow, Smith and Smith,[1] of the Fearing Research Laboratory, Brookline, Massachusetts, collected, by means of soft rubber cups, thirty-seven specimens of menstrual discharge from normal parous women. Pooled samples from each woman were placed in the refrigerator, control samples of citrated venous blood being collected from the same individuals.

The Brookline gynecologists found that menstrual discharge is lethally toxic for normal, mature female rats, if injected subcutaneously in 0.1 to 1.0 cubic centimeter doses. Toxicity was greatest during the preëstrus period. Within 24 hours after the first injection, the animals were usually "hunched up," water intake was increased, the nose and inner canthi of the eyes were encrusted with blood, and a firm, wide area of edema had developed about the site of the injection. Death usually resulted within 48 hours. At autopsy widespread edema, with capillary hemorrhages, were noted in the lungs

† This department of California and Western Medicine presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

1 Roberts, E. C., and Jones, L. R.: Proc. Soc. Exper. Biol. and Med., 47:11, 74 (May), 1941.

2 Freund, Jules: Amer. Rev. The., 12:124, 1925.

3 Mudd, S.; et al.: Jour. Exper. Med., 52:313, 1930. Jones, F. S.: Jour. Exper. Med., 46:303, 1927; 48:183, 1928. Delues, Edna: Jour. Infect. Dis., 60:55, 1937.

1 Smith, O. W., and Smith, G. V. S.: Proc. Soc. Exp. Biol. and Med., 44:100 (May), 1940.

and other internal organs, with occasional blood in the urinary bladder. The most constant lesion was in the adrenal cortex. In rats that died early, adrenal hemorrhages might be the only demonstrable lesion. With later deaths, widespread adrenal necrosis was microscopically demonstrable.

If the injections were started at the beginning of the post-estrus period, the animals were more likely to survive, and to develop a relative immunity. Male rats and spayed females are highly refractory. A simultaneous injection of estrogen increases the toxicity in rats with intact ovaries; but it has no adjuvant toxic action in spayed female rats. From this the Brookline investigators conclude that "susceptibility to the menstrual toxin depends upon the presence of the ovaries," a conclusion confirmed by simultaneous injection of ovarian emulsions into spayed females which renders them susceptible. Large amounts of progesterone completely protect female rats from this toxin. From this, too, the Smiths conclude that the corpus luteum functions as an antitoxic endocrine. Chemical analyses show that the toxin is nondialysable, and found in greatest concentration in the euglobulin fraction of the menstrual discharge.

Mature female rabbits are extremely susceptible to this toxin, a single subcutaneous injection of 1 cubic centimeter often resulting in death within 48 hours. Repeated sublethal doses will immunize rabbits against the euglobulin, the resulting antiserum protecting female rats against multilethal doses of menstrual discharge.

Bacteriological examinations and control tests, with purposefully contaminated venous blood, rule out the probability that the menstrual toxin is a product of bacterial action. The toxin is apparently a specific endometrial product, which possibly functions as a hitherto unrecognized hormonal regulator of the normal sexual cycle.

The fact that the menstrual toxin is antigenic, and that its maximum toxic effects are manifest only under certain hormonal conditions, render the alleged toxic menstrual euglobulin a very promising instrument of immuno-endocrinologic research. A considerable amount of Smith's alleged effects, however, cannot be explained by our present knowledge of endocrinology and, therefore, should not be accepted without confirmation.

P. O. Box 51.

W. H. Manwaring,
Stanford University.

Of the various causes of accidental death, in the United States, motor vehicles lead; indeed, in 1939 they were responsible for 35 per cent of all such deaths, killing a total of 32,600 persons; in fact, a person died every 16 minutes throughout the year from automobile accidents. The number of deaths was two and one-half times those caused by syphilis, equal to those caused by diabetes, and one-half of those caused by tuberculosis. More children were killed by traffic accidents in 1939 than died from diptheria, measles, scarlet fever, and whooping cough combined. Besides the fatalities, 1,150,000 other persons were injured. Of every five who died in traffic accidents, two were pedestrians.

ORIGINAL ARTICLES

ADMINISTRATIVE PSYCHIATRY*

Aaron J. Rosanoff, M. D.
Sacramento

IT is my purpose today to present a brief discussion of administrative psychiatry, not in general terms, but in the more concrete terms of policies and operations of the State Department of Institutions, which are now in effect or expected to be put in effect in the near future.

In the field of psychiatry, science has outrun its applications; and I have conceived the main task of the Department to be that of introducing, in our practice, all measures and procedures that would be justified by the knowledge in our field which is well established but pigeonholed in scientific archives.

Some of these measures and procedures are new for California; but most of them had already been introduced, to some extent, during previous administrations, and we have been seeking merely to encourage their more systematic and more complete development.

OVERCROWDING IN MENTAL HOSPITALS

The mental hospitals of our State, like those of all other states in the Union, have been for many decades, and still are, in a condition of overcrowding to an extent averaging between 15 and 30 per cent beyond their capacity. During the past ten years we have been spending an average of $3,200,000 per biennium for major construction; but, at the same time, the net increase of the population of our mental hospitals has been at the rate of 840 patients per year, and for this reason the construction of new hospitals, or of additions to existing hospitals, has had no appreciable effect on the overcrowding.

The principal measures that we have planned for coping with this problem are: first, provision of facilities for prevention, early diagnosis, and timely treatment of mental disorders, with a view to stemming the flood of commitments of patients in advanced and, therefore, more chronic stages of their illness, who become, for the most part, permanent inmates of our institutions; and, second, extension of our parole system and other devices for extramural care of chronic, but inoffensive mental patients.

In other words, measures for the relief of overcrowding now consist not only of construction of additions to our institutions, but also of diminishing our intake of patients and increasing their outgo.

THE LANGLEY PORTER CLINIC

Appropriations have been obtained from the Legislature for the establishment of an acute neuropsychiatric unit on the campus of the Medical

* From the office of the director of the Department of Institutions, State of California.
Read before the Second General Meeting at the seventieth annual session of the California Medical Association, Del Monte, May 5–8, 1941.

Center of the University of California in San Francisco. This new institution, which is to be known as The Langley Porter Clinic, will be a 100-bed hospital and expected to be ready to open for reception of patients on or about January 1, 1942.

Provision has been made in the new building for a large outpatient department, which should create opportunities for preventive work.

Provision has also been made for early diagnosis and prompt institution of indicated treatment, such as fever therapy, insulin-shock therapy, chemical and electrical convulsive therapies, brain surgery for tumors or focal epilepsy, and the like.

A sort of partnership has been worked out between the Department of Institutions and the University of California, whereby much-needed training of personnel will be furnished at the new institution: training of medical students, graduate training of physicians, and special training for work in the neuropsychiatric field of nurses, social workers, and clinical psychologists.

Last, not least, provision is to be made for neuropsychiatric research. The partnership of the Department of Institutions with the University of California would seem an ideal one for the promotion of such research. The Department of Institutions has, in its hospitals, a vast amount of clinical and pathologic material, in which all neuropsychiatric research problems are rooted, and with the aid of which the necessary researches would become possible. The University of California will make available, for purposes of such researches, all necessary scientific personnel, facilities, and equipment.

ACTIVE THERAPY OF THE PSYCHOSES

Pending the establishment of The Langley Porter Clinic, the provision of active therapy of the psychoses in our mental hospitals has not been neglected. Such provision will, indeed, always be necessary for committed patients.

Attempts to introduce insulin-shock therapy in state hospitals had been made in a number of other states, and in California before the present administration assumed office. This is by no means a simple matter, and this type of therapy had been only partly successful in most institutions.

We were fortunate in being able to obtain, through the courtesy of the University of California, the services of Dr. Jacob P. Frostig, who, almost from the beginning, had participated in the original researches whereby insulin-shock therapy was developed and standardized. With him as a special instructor, this therapy was introduced at Camarillo State Hospital in the summer of 1939, for cases of schizophrenia under one year's duration, in the southern part of the State, and about a year later in Stockton State Hospital, for the northern part of the State.

There has been, both in Camarillo and in Stockton, an accumulation of a waiting list of patients requiring this treatment. Moreover, it seems desirable to extend the benefits of this treatment to cases of up to two years' duration. Therefore, at this time provision is being made for the use of insulin-shock therapy in Patton State Hospital, to be followed later by the introduction of this treatment elsewhere, probably in Agnews State Hospital.

Convulsive therapy, with the aid of metrazol has long been in use in our mental hospitals, having been found of special value in agitated depressions and in certain catatonic states.

As all know, metrazol therapy is fraught with some serious disadvantages, and seems to be destined to be replaced by convulsive therapy induced by means of electricity.

Many details of technique of electro-shock therapy are somewhat uncertain, and we have under way negotiations with the California Institute of Technology at Pasadena for the necessary research work whereby electro-shock therapy will be applied with precision, and with full control of every detail of the procedure.

In these ways steady progress is being made along the line of raising the recovery rates and shortening the duration of acute and subacute cases of schizophrenia, and of involutional melancholia and other types of agitated depression. In these ways, too, many chronic patients with catatonic stupor and catatonic excitement improve sufficiently to become better behaved and easier to care for, helpful in the institutions, and eventually, suitable for release on industrial parole or for family care.

EXTRAMURAL CARE OF MENTAL PATIENTS

For many years there has been a trend in the Department of Institutions toward a more liberal parole policy. With the consent of the Governor and the Legislature, in the early part of 1939 appropriations were made available for the establishment of a division of extramural care, employing many additional social workers in our seven mental hospitals. There is now a Supervisor of Extramural Care, whose headquarters are in the Department's office in Sacramento.

The number of patients on parole from the seven mental hospitals has been increased from 2,993, on December 31, 1938, to 4,880, on March 31, 1941. Patients in extramural care are classified in three main groups: those on parole at home; those on industrial parole; and those in family care.

With the aid of old-age assistance, and with the aid of further special financing to be approved by the Legislature, we expect, in the course of the next biennium, to increase the number of patients from mental hospitals in family care by at least 2,000, thus raising the total number of patients in extramural care to about 7,000.

Although these measures have not yet been completely developed, there has been already a partial checking of the heretofore steady increase of the population of our mental hospitals. Thus, during the ten years preceding the present administration, the increase of the population of our mental hospitals occurred at the average rate of 840 per year. During the calendar year 1940, that increase was by but 143.

FEVER THERAPY FOR PREPARETIC STAGES OF NEUROSYPHILIS

For many years cases of general paresis constituted about 7 per cent of the admissions to our mental hospitals. Most of these cases reached us in advanced stages of the disease, with established mental deterioration attributable, no doubt, to extensive brain tissue destruction that had already taken place. Fever therapy applied to these cases resulted in degrees of recoveries justifying release from the hospitals in but 25 or 30 per cent of the cases. The problem is obviously one of applying fever therapy in preparetic stages of neurosyphilis.

Accordingly, our seven mental hospitals have been made available for the admission of patients with neurosyphilis who are not yet insane, but who would be received on their voluntary application and treated by means of malarial inoculation.

The task of inducing patients of this group to accept hospitalization in our institutions for this purpose has been assigned to the division of extramural care. At the present time, about one out of three of the patients with neurosyphilis, admitted to our hospitals, is admitted on voluntary application.

It has been estimated that about 2,000 persons are registered in the records of the State Department of Health who have neurosyphilis, and in whom malarial inoculation might be indicated. This is the reservoir of patients from which our cases of general paresis are recruited. The more of them we can bring into our hospitals for malarial inoculation, the fewer cases of paresis will develop. The progress thus far made in connection with this matter encourages us to look forward to a dwindling of the numbers of cases of general paresis until an almost negligible residue will remain.

TUBERCULOSIS IN MENTAL PATIENTS

It is a matter of common observation that tubercular morbidity and mortality among inmates of mental hospitals is much higher than in corresponding age-groups of the unselected population. This is due partly to the overcrowding prevailing in all such hospitals, and partly to the great difficulty that is experienced in enforcing, among mental patients, the simple habits of personal hygiene, such as refraining from careless sneezing, coughing, and expectoration; cleansing of mouth and nasal passages; and the cleanliness of hands.

Thus a special hazard of tuberculosis exists for all inmates of mental hospitals and for employees as well.

In order to minimize this hazard, steps were taken, without delay, for the segregation of actively tubercular patients in special buildings in Patton State Hospital, for the southern part of the State, and in Napa State Hospital, for the northern part.

Appropriations were secured from the Legislature for the construction of special buildings for tubercular patients in these two institutions. Such buildings have already been completed and are now housing tubercular patients at Patton; and contracts for the construction of similar buildings have been awarded at Napa.

In these ways, not only the epidemiologic problem of tuberculosis in our mental hospitals has been solved, but also greatly improved facilities for the early diagnosis, and proper medical and surgical treatment of cases of tuberculosis, have been provided.

IMPROVED DIET RATIONS FOR INSTITUTION INMATES

The Department of Institutions has, for many years, made careful provision for adequate diet rations for the inmates in the institutions in its jurisdiction. Ten or fifteen years ago the main emphasis in this connection was laid on caloric requirements. The great recent advances in our knowledge of vitamins has necessitated some revisions in our rations. The most difficult phase of the problem seemed to be how to provide, without prohibitive cost, an adequate daily supply of B-complex vitamins.

The problem was solved for us by a committee of the National Research Council in Washington, which has formulated specifications for an "enriched" flour, to be had from the large milling companies at a slight increase of cost over ordinary types of flour. We are now introducing these specifications in our orders for flour to be supplied to us by the purchasing bureau of the Department of Finance.

NEW INSTITUTION FOR DEFECTIVE AND PSYCHOPATHIC DELINQUENTS

There are, in the jurisdiction of the Department of Institutions, three correctional schools and two institutions for the feebleminded and epileptic. The work in both types of institutions is being greatly hampered by the presence in them of defective and psychopathic delinquents.

It has been the experience, not only of the California correctional schools, but also of similar institutions in other states, that permanently successful rehabilitations of inmates have been attained in but a minority of the cases dealt with.

There is a great deal of new evidence, some of which has been yielded by recent studies of delinquency and criminality in twins, indicating that there is an organic basis, in the form of residuals of cerebral birth trauma, postnatal cerebral trauma, and acute infections complicated with cerebral involvement, underlying most instances of defective and psychopathic delinquency. This fact would account largely for the poor prognosis of such cases.

The presence of defective and psychopathic delinquents in a correctional school has the effect, also, of impairing the prognosis of a good many other inmates of such institutions, by a process comparable to contagion.

Hence, there has been under way in California, for at least fifteen years, a more or less active movement seeking the establishment of a special institution for the care of defective and psychopathic delinquents. This would simplify the work of the correctional schools and raise their rehabilitation rates to at least double their present percentages. At the same time, by the timely and permanent segregation of defective and psycho-

pathic delinquents, the development of criminal careers would be prevented on a scale that would hardly be possible by the application of any other known measure.

SUMMARY

To summarize as briefly as possible: The tasks of administrative psychiatry, as we are endeavoring to perform them in the Department of Institutions, are those of preventing mental disorders and delinquency; raising the recovery rate of mental disorders by means of active therapy of the psychoses; raising the percentages of successful rehabilitations of juvenile delinquents; and providing, in extramural environments, a normal family life for many selected chronic patients from our mental hospitals.

California State Department of Institutions.

TUMORS OF THE SMALL INTESTINE*

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AND
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NUMEROUS individual case reports have been made of tumors of the small intestine, but due to their rarity there are few groups large enough to obtain a satisfactory statistical study. King, in 1917, reviewed the literature and was able to find fifty cases of benign tumors of the small intestine. In 1929, Rankin and Mayo reported fifty-five cases of carcinoma of the small intestine which had been seen at the Mayo Clinic. During the same period, 4,597 carcinomas of the rectum and colon were found, and 4,335 cases of carcinoma of the stomach were observed. In 1933, Rankin and Newell were able to find only thirty-five cases of benign tumors of the small intestine. Raiford reviewed the literature in 1932 and found 337 tumors which could be considered as authentic, noninflammatory, primary tumors. He presented a series of eight-eight cases which represented a study of 11,500 autopsies and 45,000 surgical specimens. Fifty of these tumors were benign and thirty-eight malignant.

SOURCE OF MATERIAL

This group of forty-five cases of tumors of the small intestine represents the tumors recognized in 25,621 autopsies from 1918 to 1941, and those recognized in general surgery from 1913 to 1941 at the Los Angeles County General Hospital, together with the surgery and autopsy records covering 28,390 admissions from 1929 to 1941 at the Santa Fe Coast Lines Hospital. All tumors in this group were primary lesions; no metastatic nor inflammatory lesions were included.

It is impossible to more than theorize in explaining the infrequency of tumors of the small intestine. The fact that the small intestine develops, for the most part, in the latter months of fetal life makes it reasonable to assume that there is less chance of a fetal rest's remaining. Cohnheim's theory definitely explains how certain tumors develop as the result of these rests. Investigators have attempted to explain the infrequency of small bowel tumors on the basis of the rapidity with which the intestinal contents pass through the small intestine in contrast to the relative stasis which occurs in the stomach and colon. The assumption is made that stasis produces irritation and that irritation predisposes to new growth.

Table 1 illustrates the type of tumors found in this series. Twenty-six are malignant and nineteen are benign. Adenocarcinoma is the most frequently encountered malignant tumor. Fibrosarcoma is next. Lymphosarcoma and malignant melanoma are less than half as frequent as fibrosarcoma.

Of the benign tumors, fibromyomas are found in nine cases. Three are adenomas. Two are lipomas and two carcinoids. There is one aberrant pancreatic rest, one fibroma, and one hemangioma.

Table 2 illustrates the age distribution of the benign and malignant tumors. There seems to be very little relationship between age and the occurrence of benign tumors in the small intestine. Malignant tumors in this series occur most frequently between the ages of fifty and seventy.

Table 1.—*Type of Tumors Found*

Type	Number	Per Cent
Benign		
Aberrant pancreatic rest	1	2.2
Adenoma	3	6.6
Carcinoid	2	4.4
Fibroma	1	2.2
Fibromyoma	9	19.9
Lipoma	2	4.4
Hemangioma	1	2.2
Malignant		
Adenocarcinoma	17	37.7
Fibrosarcoma	5	11.1
Lymphosarcoma	2	4.4
Melanoma	2	4.4
TOTAL	45	100.0

Table 2.—*Age Distribution of Tumors Found*

Age	Benign		Malignant	
	Number	Per Cent	Number	Per Cent
0- 9	3	6.6	0	0.0
10-19	1	2.2	1	2.2
20-29	0	0.0	2	4.4
30-39	4	8.8	3	6.6
40-49	3	6.6	3	6.6
50-59	4	8.8	6	13.3
60-69	1	2.2	5	11.1
70-79	2	4.4	4	8.8
80-	1	2.2	2	4.4
TOTAL	19	41.8	26	57.4

* Read before the Section on General Surgery at the seventieth annual session of the California Medical Association, Del Monte, May 5–8, 1941.

BENIGN TUMORS

An aberrant pancreatic rest was found in only one case. Although most commonly seen in the upper end of the small intestine, where they usually do not cause symptoms, this accessory pancreatic tissue was found at autopsy in the terminal ileum and caused an intussusception. Warthin's theory is that these rests arise from the lateral buds of the developing pancreatic duct as they enter the intestinal wall. As growth takes place in the gut in the linear direction, these rests may be carried along in either direction. Simpson, in 1927, collected a large series of these tumors and observed that there was a close relationship between the ventral pancreatic duct and the primitive yolk stalk. He theorized that small islands of pancreatic tissue might become implanted in the gut at this point.

Three benign adenomas were found in this series. These tumors are usually asymptomatic unless they reach a size sufficient to cause obstructive symptoms. They may be single or multiple and vary in size from several millimeters to several centimeters in diameter. Saint presented Hauser and Bordenauer's theory of primary epithelial change as being a possible explanation of their etiology. Saint's own theory was that a thickening takes place in the mucosa, followed by a thickening in the submucosa. The action of the intestinal contents passing along the intestinal tract causes a pedicle to form. This is followed by a glandular proliferation. Saint points out that these steps are most probably due to inflammation. He believes that these tumors are most frequently found in the areas where inflammatory reaction is commonly found.

In two of this series, carcinoids were found. Several small submucous plaques, about one centimeter in diameter, in the region of the jejuno-iliac junction, were seen in one case; in the other case there were two small submucous plaques, about three millimeters in diameter, found in the terminal ileum. Both were found, incidentally, at autopsy and had caused no clinical symptoms.

Carcinoid tumors sometimes are called argentaffin tumors because of the presence of numerous silver-staining granules as originally described by Gosset and Masson in 1914. Grossly, they usually look like submucous plaques although they may have a sessile base. Occasionally a pedunculated tumor may be found. Metastases have been reported, but rarely occur in true carcinoids. Various theories have been advanced as to their etiology. They are thought by some to represent pancreatic rests; by others to be similar to basal cell carcinoma; and by still others to possibly be related to the super-renal or other chromaffin tissue. No one theory has been proved as explaining the etiology of carcinoids.

One fibroma was found in this series. This type of tumor, histologically, is similar to connective tissue. The fibroma in this series occurred in the ileum of a boy thirteen years old. Fibromas are commonly found in the same location in older individuals. Symptoms usually are caused on a purely mechanical basis.

One hemangioma was noted in this series. The patient from whom this specimen was removed had had two previous abdominal operations in an attempt to determine the cause of profuse intestinal hemorrhages. The tumor involved 60 centimeters of jejunum. The dilated blood spaces usually occur in the submucous layers of the bowel. Intestinal bleeding is a common symptom of these tumors.

Of the nine cases of fibromyomas found in this series, eight occurred in the jejunum and one in the ileum. In six cases the symptoms caused by the tumor were those of intestinal obstruction. In two cases intestinal bleeding occurred in addition to cramp-like abdominal pain. In one case a fibromyoma was an incidental finding. It is quite probable that these tumors arise from one of the muscular coats of the adjacent bowel wall.

There were two lipomas found in this series; each was located in the ileum. In one case the lipoma produced an intussusception; in the other case, partial intestinal obstruction. These tumors cause symptoms almost entirely by mechanical complications. Lipomas may occur within the lumen of the bowel, as was found in these cases, or they may be found on the outer surface of the intestine. Odelberg found that 25 per cent of all intestinal lipomas are found in the small intestine.

MALIGNANT TUMORS

There were seventeen adenocarcinomas in this series which included lesions of the ampulla of Vater. Five tumors were found in the duodenum; all were small, varying in size from three centimeters to four millimeters in diameter. There was evidence of metastatic spread in all cases. All the patients died; one following a palliative cholecystduodenostomy, the remainder without surgical treatment. Seven carcinomas were found which were primary in the ampulla of Vater. The correct preoperative diagnosis was made in three cases. Other diagnoses were common-duct stone, carcinoma of the head of the pancreas, carcinoma of the stomach. In one case the lesion was found, incidentally, at autopsy. It is not surprising that the correct diagnosis was made in these three cases, inasmuch as localizing signs and symptoms due to obstruction of the ampulla of Vater are so striking. All seven persons died.

Three cases of carcinoma of the jejunum were found. One of the cases had a low-grade papillary adenocarcinoma in a young man twenty-four years old. This patient had survived five years without clinical evidence of recurrence. Two adenocarcinomas were found in the ileum. One case had double primary tumors, eight and eighteen inches, respectively, from the ileocecal valve. Both of these patients died.

Five fibrosarcomas were found in this series. Three were in the jejunum, and two were in the ileum. Many observers believe that sarcomas offer a better prognosis than do carcinomas. This unqualified statement cannot be evaluated. All but one case developed metastases; one patient died as the result of perforation of the tumor in the terminal ileum. No metastases were found in this case at autopsy.

Two cases of lymphosarcoma were found in this series. In a series of twenty-one lymphosarcomas of the small intestine, Raiford found all in the terminal 100 centimeters of the ileum, with one exception, the location of which was the second portion of the duodenum. Raiford's cases were found chiefly in young individuals. One case in this series occurred in the duodenum of a young man twenty-nine years old, the other in the jejunum of a boy seventeen years old.

Two cases of malignant melanoma of the jejunum were found. These are rarely found as primary tumors of the small intestine. They are very malignant, metastasizing early, and many times by way of the blood stream.

Of the forty-five cases presented, eleven either entered the hospital moribund and no complete diagnosis could be established, or a tumor of the small bowel was an incidental finding. Eighteen cases entered as surgical emergencies. Extensive roentgenologic examination could not be made. In none of these cases was a small bowel tumor suspected. Sixteen cases entered with ample time for study. Of these a correct diagnosis was made in four. Three cases were carcinoma of the ampulla of Vater, one was hemangioma of the jejunum. Roentgenologic examination, with motor meal study together with intestinal intubation, seem to offer the greatest hope of improving the number of correct diagnoses in this latter group of cases.

SUMMARY AND CONCLUSION

A series of forty-five cases of tumors of the small intestine is presented. The various types of tumors are discussed as to their location, type, and age incidence. Only one-third of the total number of cases in this series came under observation soon enough for adequate preoperative study. Early roentgenologic examination, with motor meal studies and intestinal intubation, offers considerable hope of increasing the number of cases correctly diagnosed.

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ESTROGENS: THEIR USE IN PEDIATRICS*

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THIS discussion will consider why, when, and how to use estrogens in order to keep in the zone of safety while using them. The paper will not consider the use of progesterone or pituitary factors.

Estrogen hormone preparations can be prepared by extraction from animal ovaries or by synthesis. By the method of natural extraction from tissues, sufficient hormone for clinical use would be impossible to prepare. Fortunately estrogens can be synthesized in sufficient quantities; these products are very potent, their costs are becoming sufficiently low, so that they are available and practical for clinical use. Myriads of trade names are now on the market. A product should be of reliable potency before being used.

Estrogens are now available for use by mouth, by vagina, by inunction, by implant subcutaneously, and by injection. One can avoid needling a patient and can secure a good response, which thus makes estrogen usage in pediatrics very attractive. As a matter of fact, I would prefer not to inject in certain problems, but to use estrogens by other routes since this would more likely insure continued therapy with better results and less distress for all concerned.

The hormone, called alpha estradiol, elaborated by follicles of the ovary, is only one of several estrogens. Others are stilbestrol, triphenylethylene, etc. As stated, the estrogens can also be synthesized. The alpha isomers being more active than the beta, and the organic esters being more slowly absorbed and excreted, estradiol is most often used in these forms. Estrogens occur as three general chemical types—estradiol, estrone, and estriol. Because of their varying chemical structure they are absorbable with very little alteration or attenuation by different body tissues, and thus can be administered to the patient by different routes. The intestinal mucosa will absorb estriol and estradiol; the vaginal mucosa mainly absorbs estrone; the skin, subcutaneous and muscle tissues, estrone and estradiol. Obviously effective oral and vaginal application are particularly helpful in pediatrics, since injection is not the only available way. Indeed, Dr. Evelyn Anderson of the University of California has recently announced that she can induce absorption through the oral mucosa, an impossibility hitherto. Doctor Anderson suspends estrogen in propylene glycol, and even in drop dosage under the tongue effects are very rapid. Estrogens can also be given, if indicated, into vein or peritoneal cavity with rapid and pronounced effect.

Estrogens in ordinary therapeutic doses do not stimulate the ovary, but are only substitutive, as is insulin. Primarily, estrogens activate the secondary sex characteristics, and their development is of a more permanent nature. However, in heavy doses estrogens may have a stimulating effect on the pituitary body, which gland may then cause a permanent ovarian follicular activity and thus menstruation. Excessive doses of estrogen depress the pituitary.

INDICATIONS

In pediatrics the usual usages for estrogens are in the problems of adolescent menstruation and, occasionally, mastopathies and vulvovaginitis. There are other uses—unusual ones—which will be mentioned.

The dosage is variable and individual. In general, the desideratum is to stimulate the normal cyclic variation of estrogen production. Often the dose is much higher initially to induce change, and lower, as maintenance, after the changes are effected. Occasionally, as in vulvovaginitis, it is desirable to give rest periods of seven to ten days after each three to four weeks of treatment. Thus cumulative effects and possible resistance to the estrogen are avoided. The induction of precocious puberty when undesirable can be prevented by avoiding excessive single doses. In ordinary thera-

* From the Department of Pediatrics, University of California Medical School, San Francisco.

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TABLE 1.—*Lists a Few of the Commonly Known Estrogens Classified Under Their Particular Chemical Group.* A list of costs was included in the original table, but because of the great variability and to save space, this was deleted. Note the route of administration varies with the chemical structure.

Preparation Trade Name and Company	*Source of Material*	*Administration*			
		Injection	Oral	Vaginal	Percutaneous
Estrone	Mixed, natural, synthetic or				
(Ketohydroxyestrin)	isolated from	+	+	+	
Amniotin—Squibb	human pregnancy	+		+	
Estrone—Lilly & Abbott	urine and placenta	+		+	
Theelin—Parke, Davis					+
Menformon, Kolpon—Roche					
Estradiol	Synthetic. From				
(dihydroxyestrin)	sterol, etc.				
Dimenformon—Roche			+		
Ovocylin—Schering			+	+	
Progynon-DH		+	+		−
Stilbestrol		+	+		
Estradiol Benzoate	Synthetic.				
(dihydroxyestrin)	From sterols				
Ben-ovocylin—Schering		+			
Progynon-B—Schering		+			
Dimenformon benzoate—Roche		+			
Estradiol Proprionate and Diproprionate	Synthetic. From sterols				
Dimenformon diproprionate		+			
Di-Ovocylin		+			
Progynon-DP					
Estriol	Synthetic.				
(trihydroxyestrin)	From sterols				
Theelol—Parke, Davis			+		
Estriol—Lilly, Abbott	Human pregnancy urine and placenta		+		
Emmenin, Ayerst	Ester of trihydroxyestrin		+		

peutic dosage this need not be feared. Likewise, malignancy need never occur. As a matter of fact, for this to occur tremendous single doses have to be frequently repeated over a long period of time; nay, it will probably never occur in a human being.

The menstrual disorders of an adolescent now merit therapy, since the present estrogens are so effective and can be given by routes easier than injection. Yet not all cases are relieved. Patients should be thoroughly examined to detect any deviations in hygiene, diet, nutrition, or any other disease. Blood counts, blood pressure and local examination of external genitalia, and particularly rectal palpation of internal genitalia, should be done. If indicated, basal rate and other endocrine laboratory procedures should be carried out. After all, relief can be given with other than endocrine therapy, thus avoiding the error of ascribing an endocrine cause to a menstrual disturbance. However, one must remember that, when indicated, a small dose of thyroid often is dramatic, and that the patient actually had a latent hypothyroidism.

Primary amenorrheas require large doses (1.0 10.0 milligrams weekly by injection), to build up the proliferative phase. The uterine hypoplasia can be helped by oral administration of 0.5 to 1.0 milligrams daily for a two-week period. A girl of fifteen or sixteen years should not be allowed to go much longer without attempting this artificial induction, especially if no secondary sex characteristics are present. Since estrogens only are being considered in this paper, little will be mentioned about pituitary gonadotropins. However, they are a logical choice, singly or with estrogens.

In secondary amenorrhea, oral treatment in small doses (0.3 to 0.5 milligrams daily) can be used at the start, but injection (for instance 2 milligrams every four days, six times each month) may be necessary. Dosage will depend on the degree of uterine infantilism.

Dysmenorrhea, if there is uterine hypoplasia, merits treatment with estrogens, 2.5 to 5.0 milligrams, injected twice weekly during the first two weeks of the intermenstruum to stimulate the normal cyclic production by the ovary, may build up the uterine muscle, resulting in more coördinated and less painful contractions. Five-tenths to one milligram daily, orally, in the first two weeks of intermenstruum, or .01 to .05 milligram daily throughout the cycle have been successful. Alternation with pituitary gonadotropins may be tried. Excessive doses of estrogens in the midcycle, to suppress ovulation, may relieve dysmenorrhea. The pain from an antiflexed uterus has been relieved by estrogens.

Menorrhagia and metrorrhagia are bothersome for young girls, often dangerous, and, as such, estrogen treatment may be tried and often may cure or alleviate. Injection of large doses or oral dosage in the last half of the cycle are the choices.

Occasionally, mastopathies require more than the usual palliation—analgesic drugs, cold packs, and support of the breast. Pain is relieved by several thousand international units injected daily just prior to menstruation or moderate dosage through the cycle. Small doses orally also can be used just before bleeding. Cystic disease and adenosis will worry mothers. One milligram, injected twice weekly for three weeks intermenstrually, is in order. The estrogens are lacking, and their use actually counteracts excess of progesterone.

The endocrine care of vulvovaginitis is now common medical knowledge since Lewis, in 1933, first used pituitary-like gonadotropins. Endocrine

therapy is the best treatment at present, and estrogens are the endocrine of choice. This disease has been more efficiently treated by local vaginal administration than by other routes. After all, it is only a local disease. Generalized effects are far less likely to occur, especially breast development from vaginal suppositories. Personally, however, I favor oral or inunction therapy over injections or vaginal suppository, because the oral or skin route is painless and prevents genital sphere fixation in the child's mind, though possibly more expensive. Estrogens are just as useful for the nonspecific cases which in this area are probably as common as the gonorrheal cases. Treatment requires about two months' time. The following doses are recommended: orally, 0.3 to 0.5 milligram daily; vaginally, 0.1 to 0.4 milligram in capsules or suppositories daily; inunctions, 0.5 to 1.0 milligram before retiring; by injection (intramuscularly), 0.5 to 1.0 milligram twice or thrice weekly. Injection is preferred by some physicians. Treatment should be suspended after three weeks for one week.

Uses other than for menstrual disorders, breasts, and vulvovaginitis include a group of diseases which are either obliterated by puberty or improved at puberty. Some diseases of this nature are laryngeal polyps, epidermolysis bullosa, trophic and nutritional disturbance of epiphyses (Legg-Perthé's and Osgood-Schlatter diseases). One should preferably treat with the gonadal hormone similar to the patient's sex. As a rule, the dosage of estrogens used for such puberty-limited diseases is very high, much higher than the usual safe therapeutic doses heretofore prescribed, and such high dosage may not be considered advisable or safe. Precocious development of secondary sex characteristics, without true maturity (menses and spermatogenesis), has occurred in most cases. Yet, faced with a bad problem early in life, such precosity may be less of an evil than certain of these puberty-limited diseases. I am thinking of a two-year-old who may require numerous anesthesias, removal of polyps, a change also of voice from polyps, possible malignancy, etc., during the next twelve years. Estrogens have been helpful, even when sprayed on polyps.

Migraine can be treated with encouraging results even orally. It does occasionally occur in children. If at all associated with ovarian dysfunction or related to the cycle rhythm, ordinary doses (0.2 milligram) can be injected three times weekly or taken daily orally. Occasionally there have been encouraging results in alopecia, impetigo, eczema, dry skin, and acne (when associated with menstrual irregularity). Others have reported favorably on atrophic rhinitis and ozena, asthma occurring around menstruation and a number of other conditions apparently unrelated to ovarian function. Finally the premature may be successfully carried along by .05 milligram daily orally or subcutaneously, lessening initial weight loss and increasing the percentage of survivors.

University of California Hospital.

CANCER OF THE PROSTATE*

A REPORT OF THIRTY-FOUR CASES SEVEN AND EIGHT YEARS AFTER TREATMENT BY TRANSURETHRAL RESECTION

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As habits acquired in youth persist throughout life, so subjects in which we become interested early in our medical careers intrigue us as we approach its close. The subject of my thesis for a master's degree in urology was cancer of the prostate, and, ever since, these cases have interested me profoundly. Once I reviewed the histories of one thousand cases of cancer of the prostate in an endeavor to ascertain what their life expectancy was at various times in the duration of the disease; how frequently and how early bone metastasis appeared, and how long these patients might be expected to survive if they were relieved of their urinary obstruction and the malignancy allowed to run its course untreated.

In 485 of these 1,000 cases, no form of treatment had been received. The average duration of the disease from first symptoms to death was a little short of three years. Obviously, then, any form of treatment, to be considered effective, should lengthen this period. It was interesting to find that when metastasis had occurred at the time of examination, two-thirds of the patients died within nine months.

More recently, James E. Kahler, in partial fulfillment of the requirements for his master's degree in pathology, made a pathologic study, as I did, a clinical one. His material consisted of 195 carcinomas of the prostate, of which seventy-two were discovered clinically and 123 at postmortem examinations. He made several original findings and confirmed others generally believed. For example, that 17.3 per cent of men over fifty may be expected to have cancer of the prostate. Surprisingly enough, he found that the greater percentage of prostatic cancer is recognizable neither clinically nor on gross examination at necropsy. In fact, fifty-four of his cases were obtained by taking additional slides from 490 prostatic glands, unselected except that the gland had been diagnosed nonmalignant, both clinically and on routine macroscopic and microscopic postmortem examination—a finding which demonstrates how far advanced this form of malignancy must be in order to be recognized clinically. Of all the cases in his series which had been diagnosed clinically, in over half, upon postmortem examination distant metastasis were present. He found that whenever the disease was discovered microscopically it could be demonstrated macroscopically in the gross specimen in only 7 per cent of the cases.

Many years ago, Scholl and I reviewed sixty-two cases of cancer of the prostate which had been discovered upon pathologic examination of sup-

* From the Department of Urology, College of Medical Evangelists.
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posedly benign prostates removed by both perineal and suprapubical operations. Interestingly enough, only three of these patients survived over five years, although the malignancy was so early as to be completely unsuspected clinically. As a result of our findings, we made, in 1921, the rather timid statement "that when the disease has advanced sufficiently to be recognized clinically, the possibility of surgical cure is diminished."

Experience and observation, during the past twenty years, have only tended to confirm this belief, and reports such as Kahler's seem to corroborate it; for he writes: "The microscopic diagnosis of prostatic carcinoma, as for ther tissues of the body, depends (among other things) on such criteria as undifferentiation of cells, loss of polarity, and invasiveness and avidity for basic dyes. There is, however, one criterion which may be peculiar to the prostate gland that supersedes all others: perineural lymphatic involvement. While extension of a carcinoma to a perineural lymphatic lying in its path is not by any means restricted to prostatic carcinoma, the abundance of sympathetic fibers within, and particularly around the prostate gland, and the apparently ideal conditions for growth of prostatic carcinoma in the lymphatic surrounding these fibers, forms a definite basis for its malignancy."

He found "localized tumors, many of which were small enough to occupy only one or two low-power microscopic fields, showed as high an incidence of perineural lymphatic involvement as large tumors involving the entire prostatic gland."

He then concludes: "It is evident, therefore, that local removal of the tumor itself . . . does not eradicate all of the tumor tissue even in the case of neoplasms of a low grade of malignancy. The demonstration of lymphatic pathways direct to the bone, rather than to regional nodes, raises the question as to whether an operative procedure could be made sufficiently extensive to hope to cure the disease."

Certainly his work must be accepted as demonstrating the rarity of ever diagnosing cancer of the prostate by any means now available sufficiently early to be able to promise even a probable cure. For the success of any method of cure must depend upon the extent to which the perineural lymphatics have been involved; and this, according to Kahler's work, bears no relationship to the size of the malignancy and is impossible of demonstration by rectal palpation.

COMMENT

Once cancer of the prostate has become diagnosable by the examining finger, the possibility of its cure is so remote that procedures which either jeopardize the life of the patient or subject him to extensive suffering, hardly seem justified.

Believing this, I feel we should try to ascertain as accurately as possible what palliative measures have to offer, and to comfort our patients with the assurance that, in this disease at least, early recognition has little, if any, effect on the outcome. Certainly, he who informs these unfortunates with cancer of the prostate that "it's too bad you didn't discover this earlier," has little foundation for his cheerless words.

In any large series of cases of malignant disease there are always a few patients who live many years. Thus, in my series of 485 untreated cases, there were four patients who lived more than three years and two of them more than ten years. Such cases are usually explained as errors in diagnosis, but when the diagnosis is based on microscopic examination of tissue this explanation hardly holds. Thus, in one of these cases, a malignant metastatic lymph node was removed ten years after the initial diagnosis of cancer of the prostate. The fallacy of attributing to any form of treatment all the favorable results obtained is thus graphically illustrated. When it is recorded that so many patients with cancer survived so many years following treatment, one should never forget that the chances are that a few of these survivors would have lived that length of time if no treatment had ever been given, while others might have been recorded among the living except for the mortality associated with the particular form of therapy employed.

It is necessary, therefore, in order to properly evaluate any form of treatment of malignancy, to keep this point constantly in mind. In this small series of thirty-four cases having transurethral resection during 1932 and 1933, we find three patients who lived over five and a half years. Two are dead, but one is still alive over seven and one-half years after his resection. I seriously doubt that he is cured. His wife, in a letter dated January 21, 1941, writes:

"Hugh is in splendid health. Weighs about 190 pounds. Will be eighty-three in August. Takes care of a big garden, thirty hens, a cow, and a big lawn. He has just finished digging and cutting up a very large apple tree he planted fifty years ago."

In some reports on the treatment of malignancy, these three cases would appear as five-year cures or controls; a statement which is both misleading and regrettable, for in many such patients the disease is neither controlled nor cured. Some have been known to employ the same term for these surviving over three years, even when natural course of the disease is as long.

In my series of thirty-four cases there were ten patients who lived over three years after transurethral resection, although, with the possible exception of the individual who still survives, the disease was not controlled and certainly not cured in a single instance.

That these figures represent fairly accurately what may be expected from transurethral resection of cancer of the prostate is emphasized by the findings of a similar study made by Thompson and Emmett in 1938. They reviewed 107 cases and found seventeen, or 15.8 per cent, survived over four years following resection, and that ten patients, or 9.3 per cent, were still alive in the fifth and sixth year after operation. They write: "In two cases, the carcinoma was apparently confined to the central portion of the prostate gland, for repeated reëxamination has failed to demonstrate either local recurrence of metastasis; furthermore, biopsy has been done by removing numerous pieces

of tissue from the prostatic urethra in each of these cases, and careful study has failed to disclose evidence of carcinoma. The tissue removed at the original operation has been studied again and is definitely carcinomatous. It seems possible that in these two cases a real cure was accomplished by transurethral resection."

There were two other cases in my group which I think deserve emphasis. Each was also living after a lapse of three years and may still be, for all that I know, for they have been dropped from the follow-up.

Repeating a practice initiated by Drs. Thompson and Emmett in their study of the results of transurethral resection in cases of cancer of the prostate, I asked Doctor Broders to review the tissue removed at the time of resection in all cases still living after three years. In two of the twelve cases living over this period, he found the original diagnosis to be in error. The tissue that had been removed in 1933 and reported malignant was, in fact, benign. Except for this careful recheck, I might have had the pleasure of reporting five instead of three patients living over five years, and possibly that three of my resections instead of one had survived over seven years.

It seems to me quite within the realm of possibility that other reported cases of cures which one reads in the literature may be due to similar honest errors on the part of the pathologist who first examined the tissue.

We all know this was true in the first large series of radical cures of cancer of the breast reported by Halstead, which, upon review of the tissue by Bloodgood, were pronounced in a goodly minority to be benign.

Not many years ago the professor of urology of one of the largest midwestern state universities confided to me that the incidence of malignancy of the prostate in his cases of transurethral resection was in excess of 30 per cent. I suggested that he send some of the slides to Doctor Broders for confirmation and the error was corrected. It seems a well-established fact, from figures of various urological clinics, that the incidence of cancer of the prostate is between 15 and 20 per cent.

I doubt if too great an emphasis can be placed on this possible source of error in diagnosis. Certainly, I feel sure few would have questioned my honesty if I had included these two cases just referred to with the other three who survived over five years. In so doing, I could, in all honesty, have reported a 10 per cent of five-year controls of cancer of the prostate by transurethral resection, all proved by microscopic examination at the time of operation; end-results statistically the equal of any form of treatment of cancer of the prostate in unselected cases.

That transurethral resection for cancer of the prostate has unquestionably prolonged the lives of these unfortunate individuals, seems indicated beyond question of a doubt, for ten of the group outlived the average duration of the disease, measured from its first symptoms to death, in spite of the fact that, in many cases, it was already considerably advanced at the time of resection. Nine of the group survived less than a year following the operation, but none died as a result of an attempt to cure them. There was no operative mortality.

It has been believed for a considerable time that cancer of the prostate, with a few rare exceptions, originated in the posterior lobe. As this lobe is not removed by transurethral resection, some have logically argued that resection was contra-indicated when malignancy of the gland was suspected. Some have gone as far as to hold that, inasmuch as every fifth case of prostatic enlargement would prove to be malignant, that resection verged upon malpractice.

Fortunately, the investigation of Kahler, referred to earlier, showed that only in the median lobe did he never find carcinoma changes originating, and that its incidence in the posterior lobe was a little less than in the laterals. Comforting findings for those who believe palliative rather than curative surgery is indicated in this disease.

True, over twenty of these thirty-four patients succumbed within two years of their resection; but they had been relieved of their urinary difficulties considers that they were unselected cases, and that only four others died during the third year, I think it may be asserted without fear of contradiction that transurethral resection offers to the vast majority of patients with cancer of the prostate a method of treatment devoid of great risk; free of discomfort, and which leaves them in possession of their normal physiologic function.

College of Medical Evangelists.

POWDERY MILDEWS AS ALLERGENS*

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THE failure of some hay fever and asthma patients who are sensitive to pollens to react to treatment has long puzzled allergists. That their sensitivity might be due to plant spores other than pollens was not for many years suspected. In the spring of 1939, during a routine study of the deposits on pollen slides exposed daily at various stations on the Mills College Campus, at Oakland, California, an unknown type of spore occurred in great numbers. Careful study of the surrounding vegetation revealed that the source of these spores was a powdery mildew *Microsphæra Alni* (Wallr.) Wint. growing upon the leaves of the Valley Oak (Quercus lobata Nee). In the light of seasonal occurrence of these spores it seemed desirable to test certain individuals with an extract prepared from them. Spores were collected and an extract of their atopens was made with Coca's solution, under the supervision of Dr. Robert K. Cutter at the Cutter Laboratories in Berkeley, California.

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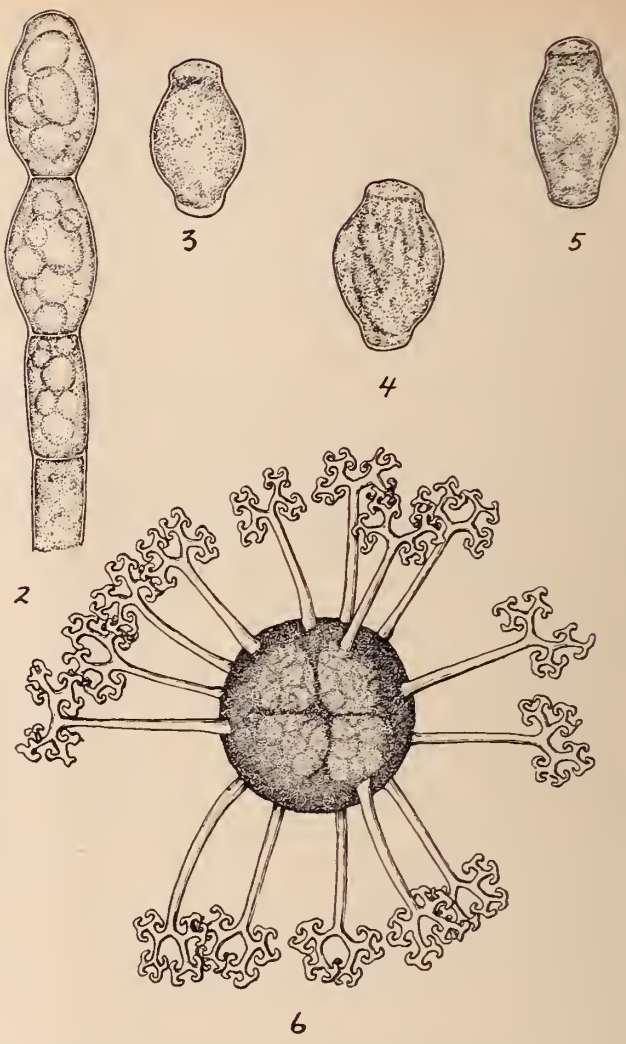

Fig. 1.—Leaf of Quercus agrifolia Nèe, showing mycelium and perithecia. x 1.
Fig. 2.—Conidiophore, with conidiospores being formed. x 600.
Figs. 3, 4, and 5.—Conidiospores. x 600.
Fig. 6.—Perithecium, showing branched appendages. x 900.

CLINICAL MATERIAL

One hundred cases were chosen which showed seasonal symptoms and were known to be sensitive to pollen. The reactions were traced upon cellophane paper and the results are here recorded in Table 1.

The positive reaction to the controls may have been due to the patient's sensitivity to Coca's solution.

Relatively little experimental evidence is available with respect to the part which fungi may play as allergens. Undoubtedly among the active agents in house dust are the spores of such a fungus as *Rhizopus nigricans,* the common black mold of bread. These spores are so abundant that they usually overgrow everything else on culture plates of house dust. A few of the more common molds, such as Penicillium, Aspergillus, etc., as well as certain other fungi, have been tested clinically and have given some positive results.

TABLE 1.—*Reactions in One Hundred Cases*

Number of cases giving 4+ reaction to Microsphæra Alni extract	4
Number of cases giving 3+ reaction to Microsphæra Alni extract	25
Number of cases giving 2+ reaction to Microsphæra Alni extract	23
Number of cases giving 1+ reaction to Microsphæra Alni extract	13
Number of cases giving no reaction	34
Doubtful	1
Total positive reactions	65
Of the controls 89 gave negative results	
10 gave some reaction	
1 was doubtful	

DISTRIBUTION

The large and widespread family Erysiphaceæ, members of which are commonly known as mildews, blights and powdery mildews, has not previously been studied from the point of view of its allergic potentialities. The family belongs to the order Perinosporiales of the Ascomycetes. Its members are all strictly parasitic upon plants. The species are numerous and closely related. Common genera are Sphærotheca, Erysiphe, Phyllactinia, Uncinula, Podosphæra and Microsphæra.

Geographically the powdery mildews are widespread, being particularly abundant in the north temperate zone but occurring from Greenland to

the temperate regions of South America. They attain their best development during the moist periods of the year but they are by no means restricted to humid regions.

HOSTS

The number of known hosts to these parasitic fungi is continually increasing and 2,000 host species is probably a conservative estimate. Some idea of the wide variety of hosts may be obtained from the following very incomplete list, many of which are of economic and horticultural importance: alder, apple, bean, Boston ivy, barberry, birch, clover, Coreopsis, cucumber, currant, dandelion, dahlia, elm, elderberry, Euonymous, Gaillardia, grape, hop, honeysuckle, lupine, marigold, mustard, maple, oak, peach, phlox, pear, pea, poplar, rose, strawberry, tobacco, violet, verbena, willow and walnut, as well as numerous species of grass.

GENERAL CHARACTERISTICS

Many species of these fungi are known to occur in great abundance, and they all have the same general characteristics. The vegetative portion of mycelium is, with few exceptions, superficial to the host, often forming a white or hyaline, felt-like mass over the surface of leaves and young stems. Simple or lobed haustoria enter the stomata or other vulnerable points of the host, and through these the fungus absorbs nourishment. The mycelium is branched and made up of uninucleate cells.

Reproductive bodies produced in the spring and early summer are to be found in large numbers. They are simple, one-celled structures formed in chains on scattered conidiophores (Fig. 2). There is so little morphological difference between the conidiospores (Figs. 3, 4, and 5) of the various species of powdery mildews that these are of little value in their identification. They are usually barrel- or egg-shaped. Under proper conditions of moisture and temperature they will germinate almost immediately, producing a new mycelium and another crop of conidiospores within a few days. These masses of mycelia, with their conidiophores and conidiospores, cause the powdery spots on the leaf surface (Fig. 1). Under proper environmental conditions the conidiospores are released into the air in enormous numbers. They are small, 65-80μ in diameter by 130-150μ in length, and are readily carried by air currents.

Genera and species in the family are distinguished not so much by the conidial characters as by the type of perithecia (Fig. 6) or resting structures resulting from sexual reproduction. They are produced in the fall and appear as black or dark brown spheres just visible to the naked eye. They may occur in abundance. Within them are produced the ascospores which carry the fungus over the unfavorable growing season. *Microsphœra Alni* may be distinguished from all other powdery mildews by the intricately branched appendages (Fig. 6) on the perithecium.

In November, 1939, perithecia in abundance were found on the same oak trees which had produced conidiospores in the spring. The leaves were not yet shed, and the relatively thin white mycelium and many black appendaged perithecia were scattered over the upper leaf surface (Fig. 1). The spores of these fungi may be the cause of many of the baffling and unexplained allergic cases which so frequently appear. The millions of readily dispersable conidiospores produced by a single infection and the great abundance of the fungi of this group on a wide variety of hosts render these plants ideal as a causative agent of asthma and hay fever.

The authors wish to thank Professor H. E. McMinn of Mills College for his coöperation in this work.

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COMMON DUCT LESIONS: THEIR SURGICAL MANAGEMENT*

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IT is not the purpose of this paper to present any startling innovation in the management of lesions of the common duct, however much that might be desired. Rather, it is the intent to focus attention upon the fact that we are at present in possession of sufficient information and have at our disposal adequate technical procedures to permit of a somewhat standardized approach to this admittedly difficult field with a view toward the material improvement of our end-results.

Recent advances in our knowledge concerning the normal and abnormal physiology of the liver, the cause and prevention of cholemic bleeding, renewed interest in the hepatorenal syndrome, as well as a realization that the malignant lesions affecting the common duct may be successfully attacked by the same principles of early diagnosis and radical extirpation as are successful in the treatment of cancer elsewhere about the body, have all combined to generate a more optimistic spirit than formerly prevailed.

CLASSIFICATION

Since the ultimate effect of common-duct lesions is to encroach upon or obliterate the lumen of the duct and thus interfere with its function of carrying bile from liver to duodenum, these lesions may be classified as (1) those causing pressure from without, (2) those causing pressure from within the lumen, and (3) those arising within the wall of the duct itself.

Of lesions causing pressure from without, carcinoma of the head of the pancreas is by far the

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most common, followed in frequency by metastatic malignancies arising elsewhere, enlarged glands, Hodgkin's disease, or other lymphoblastomata. Another important cause of obstruction arising from without the duct is chronic interlobular pancreatitis. Stones form the only important cause of obstruction arising within the lumen of the common duct, although instances of obstruction by worms such as ascaris lumbricoides, and liver flukes are on record. Of the disturbances arising within the wall of the common duct itself, benign stricture, usually due to operative trauma, is by far the most frequently seen. Benign tumors, such as papilloma, adenoma, lipoma, fibroma, and neurofibroma, have been recorded, but these are rare. Malignant tumors, while infrequent, are not rare, and are practically always carcinoma.

DIAGNOSTIC PROBLEMS

The most common and prominent symptom of common-duct involvement is jaundice. Thus, the differential diagnosis involves the consideration of all conditions which may give rise to a visible deposit of bilirubin in the tissues. McNee classifies jaundice as follows: (1) hemolytic; (2) hepatogenous; and (3) obstructive. With the first two causes, we are concerned as a matter of elimination. The diagnostic problem in common-duct disorders is to determine, insofar as is possible before operation, the nature and location of the obstructing agent.

The history of a recent surgical attack upon the biliary tract preceding the onset of jaundice, or the presence of an external biliary fistula, are suggestive evidence that the lesion is traumatic, although there must be borne in mind the frequent occurrence of a missed common-duct stone. A positive direct Van den Bergh response indicates, of course, an obstructive type of lesion. But if the jaundice is of considerable duration, the response may not be sharp-cut and may be diphasic, indicating both obstructive and hepatogenous types of jaundice. The galactose tolerance test and the hippuric acid test are of some value in indicating rather marked liver damage. Also, in severe hepatic dysfunction, the blood cholesterol and cholesterol esters are definitely depressed.

STONE AND MALIGNANT OBSTRUCTIONS

The differential diagnosis between stone and malignant obstructions of the common duct is difficult and often impossible to make prior to exploration. Courvoisier's law, which postulates an enlarged soft gall-bladder in the presence of malignant obstruction, and a hard, shrunken gall-bladder in the presence of calculus, are helpful in certain instances, but not entirely reliable. The intermittent nature of the jaundice in calculus disease, together with the chills and fever known as Charcot's syndrome, are of some value in differentiation. Recently, Watson has stressed the importance of the variation in the amount of urobilinogen in urine and feces in the various pathologic instances causing jaundice. He found that in cases of the stone in the common duct there were always present appreciable quantities of urobilinogen in both urine and feces, although these quantities might be somewhat less than those found in normal individuals. However, in obstruction due to malignancy there was found little, if any, urobilinogen in either feces or urine. He stressed the necessity of making these determinations upon specimens collected over five-day periods and averaging the results.

Pain is not a reliable symptom from the standpoint of diagnosis, because of its great variability. Frequent gastro-intestinal hemorrhage in a jaundiced patient is suggestive of carcinoma of the ampulla of Vater. The x-ray sometimes shows a widening of the duodenal "C" in cases of carcinoma of the head of the pancreas, together with other distortion of the duodenal outline, not at all conclusive.

PREOPERATIVE MEASURES

The liver has been called the commissariat of the body. Its functions are many and varied, the most important of these being its rôle in the metabolism of carbohydrate, protein, fat, and vitamins; the secretion of bile; a part played in the process of hemopoiesis; and in the maintenance of substances necessary for the coagulation of blood. Thus, an active preoperative appraisal of its status is essential. In a jaundiced patient the hippuric acid test is of value in estimating the degree of risk. If, following a dose of six grams of sodium benzoate, there is excreted one gram or less of hippuric acid in four hours, surgery is hazardous. If the secretion is five-tenths of a gram or less, surgery is absolutely contra-indicated.

Of cardinal importance is information concerning the bleeding tendency. This is measured by means of the Quick prothrombin clotting time, which estimates the patient's clotting ability as a definite percentage of a normal control, and thus reflects quite accurately any deviation from the normal prothrombin content. This bit of information and its practical application in the prevention of cholemic bleeding are the most recent outstanding contribution to bile-tract surgery. The level of the blood protein is also of importance. In prolonged and severe hepatic damage there is usually a definite decrease in both the blood albumin and the globulin, with a reversal of the usual ratio of two parts of albumin to one of globulin. Renal function and urea clearance should be ascertained. The level of serum bilirubin is important. Operation is less hazardous when performed in the presence of a more or less stabilized serum bilirubin level, even though that be quite high than if done when the level is advancing quite rapidly. Given a jaundiced patient upon whom it is proposed to perform an operation for biliary obstruction, it is highly desirable to restore that patient's liver and renal physiology to as nearly a normal state as possible before the operation is performed.

Diet.—The diet should be high in carbohydrates, containing from 350 to 500 grams daily. Often intravenous glucose is necessary in order to insure that amount. It has been demonstrated by Bollman and Mann that in the experimental dog with biliary obstruction a diet of meat exclusively is not tolerated, but that the same animal will survive months

on a diet of milk and syrup. Meat, or meat extractives, developed ascites in such an animal, but milk and eggs did not favor such a result. Therefore, the daily intake of protein in a jaundiced patient should be from one to two grams of vegetable and dairy protein per kilogram body weight, with the addition of just enough meat to increase the palatability of the diet.

Inasmuch as a damaged liver is unable to handle fat well, the amount of fat should be limited to 45 or 50 grams per day.

The patient with an impaired liver needs larger quantities of vitamins than are contained in normal diets. Walters and Snell, in their book "Diseases of the Gall-bladder and Bile Ducts," recommend the daily administration of oleum percomorphum 30 minims; orange juice,12 ounces; Valentine's extract of liver, 2 ounces; parenteral crystalline thiamin chlorid, 3 to 9 milligrams, brewer's yeast tablets (Harris or Mead), 3 to 5 with each meal. Vitamin K, in the form of Klotogen (Abbott) or some other reliable preparation, should be given in doses of a thousand units three times a day, together with bile salts in doses of at least ten grains three times daily. The prothrombin clotting time should be checked just before operation to assure that it has attained approximately normal values; that is, a clotting time of twenty seconds. In patients with lowered blood protein there is no substitute for transfusion of whole blood or plasma.

POSTOPERATIVE COMPLICATIONS

If the patient has been well prepared, as above outlined, with due regard for the prevention of the two most important postoperative complications, that is, cholemic bleeding and hepatic insufficiency, postoperative care should not be so difficult. Administration of glucose intravenously is still the sheet anchor of postoperative care. Postoperative administration of Vitamin K and bile salts should be continued for several days, unless and until the prothrombin clotting time is shown to be normal. Occasionally, notwithstanding satisfactory preoperative preparation, the symptoms of hepatic insufficiency, or the hepatorenal syndrome, supervene. This condition is to be suspected when the patient becomes stuporous, restless, or the urinary output decreases and the blood urea increases, when jaundice deepens and when drainage from a T-tube, which had formerly been satisfactory, becomes thin and watery.

Oxygen is of value, together with transfusion, to improve the oxygen transport system of the blood. If these measures fail, the intravenous use of one or two per cent sodium lactate in normal salt, 1,000 cubic centimeters once or twice daily, is often useful.

Postoperative atelectasis, as the forerunner of postoperative pneumonia, should always be considered in the presence of a rapid pulse with cyanosis or evidence of respiratory embarrassment. For the treatment of postoperative shock, next in value to transfusion of whole blood or plasma, is a 6 per cent solution of acacia in normal salt, 500 cubic centimeters given intravenously.

TRAUMATIC STRICTURES

The best treatment for stricture or other abnormalities of the common duct, consequent upon operative trauma, is their prevention. To avoid such injuries an intimate knowledge of the usual anatomy of the extrahepatic biliary tract, and the structures of the hepatoduodenal ligament together with their frequent variations, is essential. In operating upon these structures, it is inexcusable to sever or ligate any one of them without making absolutely sure of its relationship to the other vital parts. Probably the most common error in this connection is the ligation of the right hepatic artery in place of the cystic artery, thus diminishing greatly, if not completely stopping, the blood supply to the right lobe of the liver, and often causing death, with symptoms usually ascribed to hepatic insufficiency or the so-called "liver death," which is not in reality a liver death at all in the accepted sense.

Another disastrous mechanical error is the partial or complete severance of the common duct because of its inclusion in the clamp around the cystic duct. Whether one performs the operation of cholecystectomy from below upward, or from above downward, makes very little difference, provided he uses that technique with which he is thoroughly familiar and follows the cardinal principles of identifying the anatomy before severing or ligating any structure.

Another important prophylactic point in all attacks upon the common duct is to explore the duct thoroughly and ascertain insofar as possible the kind of abnormality present before the gall-bladder is sacrificed. This will permit a later anastomosis of the gall-bladder to the intestinal tract in case the common-duct lesion is such as to preclude its removal and at the same time maintain duct continuity. Complete severance of the common or hepatic duct occurring during surgery, and recognized at the time, should be repaired immediately by suturing around a T-tube.

Benign common-duct stricture following surgical trauma presents itself in several different forms, depending upon the level at which the duct is occluded. The simplest is the narrow annular stricture occurring in the readily accessible portion of the duct. This is best treated by a longitudinal incision through the stricture and transverse closure. Complete occlusion of the common duct below the cystic duct, under circumstances which permit the mobilization of the proximal and distal ends, is repaired by interrupted sutures around a T-tube. This usually gives excellent results, provided undue tension can be avoided by satisfactory mobilization of the divided ends. If it is impossible to mobilize enough of the distal end to permit satisfactory anastomosis, then the common duct or the hepatic duct must be implanted into the duodenum or the jejunum, a process being known as choledocho or hepatico-enterostomy, performed after the method of W. J. Mayo. Usually a rubber tube or catheter is employed as a foundation for such anastomosis, and in order to insure the patency of

the opening while healing occurs. In instances in which the occlusion lies high in the hepatic duct, or involves both the right and left hepatic ducts, it is sometimes necessary to implant these ducts separately into the duodenum or jejunum, this procedure often being technically very difficult.

The Kehr operation is suggested for those instances in which it is impossible to identify either right or left hepatic duct for the purpose of anastomosis with the intestinal tract. This is performed by denuding an area on the under surface of the right lobe of the liver about one by two inches; then with deep thrusts of the pencil-tip, cautery openings are made into the substance of the liver, thus opening up several bile radicals. A loop of jejunum is anastomosed snugly to the area of liver so denuded. This operation is called hepatojejunostomy. Its application is very limited, and its success highly questionable.

The implantation of an external biliary fistula into the duodenum or jejunum has been successfully accomplished on several occasions. The fistula is mobilized by careful dissection sufficiently to permit its introduction and suture into the duodenum or jejunum. Lahey has emphasized the necessity of leaving as much of the fistula as possible in contact with the under surface of the liver in order to facilitate its blood supply. All of the implantation operations are subject to the frequent occurrence of ascending cholangitis and the development of stricture in the anastomoses so formed, but they do offer considerable to a patient afflicted with this kind of biliary obstruction.

On my service at the Los Angeles County General Hospital a year ago, I performed an hepaticoduodenostomy on a woman for a lesion of the common duct not amenable to other repair. Her postoperative course was not particularly stormy. From time to time, she experiences some distress in the upper abdomen, with slight jaundice and low-grade fever. Her stools are normal in color. She is undergoing recurrent attacks of low-grade cholangitis, but it is believed her ultimate outlook is good.

STONE IN THE COMMON BILE DUCT

Stone in the common bile duct occurs far more frequently than was formerly believed. Authorities differ in their estimates of frequency, some stating that one patient in five suffering with stones in the gall-bladder has common-duct stones, while others place the estimate as high as one in three. As the result of this viewpoint, more common ducts are being explored for stone in connection with the operation of cholecystectomy for stones in the gall-bladder. It is pretty generally agreed that, in addition to the cholecystectomy for stones in the gall-bladder, the common duct should be explored in patients giving history of rather intense or prolonged jaundice, intermittent fever, and in whom the common duct is enlarged, thickened, or is seen to have lost its normal bluish color. Some operators go as far as to contend that all common ducts should be explored in the presence of stones in the gall-bladder.

The removal of a stone from the comon duct may be very easy or extremely difficult. It is not our purpose to outline at length the various technical maneuvers involved, but it may be said that in this field of surgery one's ingenuity is taxed to the utmost.

Supraduodenalcholedochotomy, retroduodenalcholedochotomy preceded by the mobilization of the duodenum by the method of Kocher, transduodenalcholedochotomy, all have their places and particular indications. It is our custom to drain the common duct with a T-tube in every instance in which it is opened or explored.

One of the most annoying features of surgery for stone in the common duct is the stone that was missed at operation. This is to be suspected when, following cholecystectomy or choledochotomy, the patient develops upper abdominal pain, intermittent fever, and jaundice. To obviate overlooking a stone at operation, there has developed the practice of cholangiography. Lipiodol or hippuran is injected and an x-ray taken immediately. This entails some time and inconvenience, but is often worth the effort.

BILIARY DYSKINESIA

Both the medical and surgical literature during the past few years have contained frequent references to a condition called biliary dyskinesia. This term describes a spasm of the sphincter of Oddi, and is used in explanation of the poor result notoriously known to follow cholecystectomy for chronic cholecystitis without stones. Working upon this principle, Colp, Doubilet, and Gerber, at the Mount Sinai Hospital, have developed an instrument for the incision of the sphincter of Oddi through the common duct. They have reported several favorable instances of the use of this instrument and contend that it is perfectly safe. Their instrument is introduced through the ordinary choledochotomy incision, directed into the duodenum and then pulled backward, upon which a projecting tooth-like blade engages in the upper portion of the sphincter and removes a small wedge-shaped piece of that structure. Working entirely independently and antedating the work of Colp, Doubilet, and Gerber, according to his statement, Otto DeMuth of Vancouver has developed an instrument for the same purpose, but of a slightly different construction. His instrument is the usual olive-tipped bougie in which is fashioned a small knife. The function of the knife is to incise the sphincter Oddi, but not to excise a portion of its tissue; thus DeMuth claims that the possibility of hemorrhage is entirely obviated. This instrument has particular bearing upon the problem of missed stone in the common duct. It is stated by DeMuth that he has not had an instance of recurrent or missed stone in the common duct since the use of his instrument, inasmuch as the relaxed sphincter of Oddi makes it very easy for the common duct to expel such a stone. There should be mentioned, in passing, also the operation of Reich, in which the sympathetic innervation of the sphincter of Oddi is destroyed by careful dissection of the plexus around the lower end of the common duct.

RETAINED STONE

If, during the postoperative course of a patient with a T-tube in his common duct, there is reason to suspect the presence of a retained stone, cholangiography is performed. If such a stone is shown to be present, it may be fragmented and dislodged by the method of Pribram, consisting of the instillation of 2 to 3 cubic centimeters of ether into the T-tube and the administration of amylnitrite by inhalation. Best, of Omaha, has done considerable work in this field and has developed a technique that he calls his flush of the bile tract. This consists essentially of the use of nitroglycerin or amylnitrite, Epsom salts, and olive oil, by mouth or by duodenal tube, and atropin by mouth or hypodermic. Quite often it is possible to dislodge and expel a retained stone by these methods. Their failure, of course, indicates reoperation, which is always a much more hazardous and difficult procedure than the original operation.

Benign neoplastic lesions are very rare. When they occur in accessible locations in the duct, they can be removed by segmental resection and anastomosis of the duct over a T-tube.

Malignant lesions, practically always carcinoma, while not frequent are not rare. They may occur in any location along the course of the duct from either the right or left hepatic duct, their juncture, the juncture of the common hepatic with the cystic and along the course of the common duct or in the ampulla of Vater.

CHRONIC INTERLOBULAR PANCREATITIS

One important condition causing obstruction to the common duct by pressure from without is chronic interlobular pancreatitis. It is said that this is most often due to present or previous stone in the common duct or in the pancreatic duct, but often at operation the stone cannot be detected. The patient presents a history of gradually increasing jaundice, with vague upper abdominal distress. At operation the external biliary tract is found to be essentially normal, except that the common duct and gall-bladder may be somewhat dilated. There is found a rather hard, diffuse mass in the head of the pancreas. Exploration of the common duct reveals no stone, but some obstruction due to the pressure of this mass. The difficulty lies in differentiating between chronic pancreatitis and carcinoma of the head of the pancreas. This is often impossible at the operating table. One case history will illustrate this condition.

REPORT OF CASE

The patient was a well-developed white female, age thirty-eight years, who consulted me in 1933, complaining of abdominal pain, nausea, and vomiting, with an onset of about nine weeks previously. She had been quite jaundiced at times. She complained of sour stomach, pain occurring about four hours after meals; had lost twelve pounds during the period of her illness. Examination revealed slight visible jaundice, with some tenderness over the gall-bladder region. X-ray examination revealed a poorly functioning gall-bladder, but showed no stones. At operation the gall-bladder was found to be rather markedly dilated, soft, and contained no stones. The common duct was dilated, but no stones were palpable. There was a mass in the head of the pancreas about the size of a hen's egg, irregular, nodular, firm. The remainder of the pancreas was firmer than normal. A small piece of the pancreas was removed for biopsy. This removal occasioned considerable sharp hemorrhage, which was finally controlled by suture. The biopsy showed only chronic pancreatitis, but it was felt at the time that a representative portion of the gland had not been obtained; therefore, the diagnosis at the table was carcinoma. A cholecystduodenostomy was performed. The patient's postoperative convalescence was uneventful. In September, 1934, or fifteen months after the operation, she was delivered of a normal infant. Today her health is entirely satisfactory. She shows no symptoms referable to the gastro-intestinal tract or any evidence of metastatic malignancy; thus confirming the diagnosis of chronic pancreatitis.

LOS ANGELES COUNTY GENERAL HOSPITAL STATISTICS

At the Los Angeles County General Hospital, from the years 1929 to 1938 inclusive, there were 124 instances of carcinoma involving the head of the pancreas, the common duct, or the ampulla of Vater. Of these, 112, or 90.4 per cent, involved the head of the pancreas; nine, or 7.2 per cent, the common duct; and three, or 2.4 per cent, involved the ampulla of Vater. Thus, there is seen the great preponderance of these lesions in the head of the pancreas.

An effort was made to determine from the records of these patients their operability from the standpoint of radical removal of the pathologic process. In the records of seventy-five of these patients there was sufficient information on which to base an opinion. Of these seventy-five, there were thirty-two with definite local or distant metastasis—42.6 per cent. There were forty-three, or 57.4 per cent, without local or distant demonstrable metastasis; thus, almost 60 per cent of these patients, presumably, were entitled to an attempt at radical removal of their carcinoma. While in rare instances it might be possible to excise a well-localized malignancy of the free portion of the common duct and effect an end-to-end anastomosis of the severed ends, such a local incision would not conform to the accepted principles for the treatment of cancer; that is, widespread removal of the growth and surrounding tissues. Also, there are a number of instances on record of local removal of a carcinoma in the ampullary region, but such removals have practically always been followed by early recurrence.

WHIPPLE PANCREATICODUODENECTOMY

It is to deal with the problem of carcinoma in the region of the head of the pancreas, in accordance with the modern accepted principles of radical widespread excision, that the Whipple pancreaticoduodenectomy has been devised. Fundamental to the use of this operation is the understanding, proved by animal experimentation and subsequent clinical operation or observation, that the external secretion of the pancreas is not essential for life or a fair degree of health.

Since it is usually difficult, if not impossible, to differentiate at operation between a malignancy of the common duct and one arising in the head of the pancreas, and since this distinction is of no particular importance as regards the procedure to be

employed, the only important considerations are to determine whether or not local or distant spread has occurred. Otherwise, with a patient in fairly good condition and satisfactory preoperative preparation, the Whipple operation is the procedure of choice if one wishes to make an attempt to cure his patient. It is a prolonged operation, quite shocking, but the ends to be achieved are worth the risk. It is performed in two stages. The first stage consists of double ligation of the common duct with heavy linen and its incision between these ligatures. The ligature on the distal end is left long for identification at the second stage. The small bowel is divided about 12 to 15 inches distal to the ligament of Treitz, an end-to-side enterostomy is performed, and the fundus of the gall-bladder is anastomosed to the distal end of the jejunum. This is all of the first stage. The second stage is performed two or three weeks later, following satisfactory recovery from the first operation. The distal end of the severed common duct is identified by its long ligature. Posterior gastroenterostomy is performed. The gastroduodenal artery is identified and ligated. The entire duodenum and a large wedge-shaped portion of the head of the pancreas are excised en bloc. The ducts of Santorini and Wirsung are ligated with heavy silk or linen, and the pancreatic remnant is ligated with interrupted sutures of silk. One drain is placed in the pancreatic bed so formed. While this operation is indeed radical and its immediate mortality high, it offers the only present opportunity for complete radical cure of malignant lesions in this region.

In a recent personal communication, Doctor Whipple stated that his present tendency is to perform the entire operation in one stage in individuals who are in good condition and seem able to tolerate it. The only feasible alternative procedure is an anastomosis between the gall-bladder and the intestinal tract, preferably the duodenum. This is to be performed when the growth has extended beyond limits permitting of its radical removal, or when the patient's condition will not permit consideration of the Whipple operation. It offers, at best, only temporary palliation, records showing that the average life expectancy after these palliative procedures is about seven and a half months.

SUMMARY

In the surgical management of lesions of the common duct, a thorough understanding of normal and abnormal liver physiology is essential.

Recent advances in our knowledge of liver function are applied to common-duct obstruction.

The surgical treatment of operative strictures and the management of common-duct stones are outlined.

Missed stone and its treatment are discussed.

The principles used in the successful treatment of carcinoma of the body elsewhere are equally applicable to carcinoma involving the common duct and its neighboring structures.

The Whipple operation presents a practical application of these principles.

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SYPHILIS: FIVE-DAY TREATMENT*

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THE five-day treatment of syphilis, as introduced by Hyman, Chargin, and Leifer,[1] represents an attempt to eradicate early syphilis by means of a massive dose of an arsenical spirocheticide administered intravenously by the continuous drip method. In 1931 Hirschfeld, Hyman, and Wagner[2] showed that large amounts of a toxic substance may be given intravenously without untoward reactions, provided this substance is introduced into the blood stream with sufficient slowness. They concluded that many of the toxic reactions which follow intravenous injections are the result of speed shock. Applying this principle to the treatment of early syphilis, Hyman, Chargin, and Leifer have attempted to reach Ehrlich's original goal, namely, the total sterilization of the patient from spirochetes by one massive dose of arsphenamin.

STUDIES AT MOUNT SINAI HOSPITAL

A symposium on this subject held at Mount Sinai Hospital, New York City, on April 12, 1940, created considerable interest in this work, among both medical men and the lay public. The importance of this investigation is indicated by Moore,[3] who, in discussing the papers presented on that occasion, stated: "This investigation may represent the most important advance in the treatment of syphilis since the original discovery of arsphenamin by Ehrlich in 1909." This method of treatment is still in the experimental stage and is being investigated by the group of workers at Mount Sinai Hospital. At this institution an organization has been set up for the proper execution of the technique and for a thorough follow-up of the patients from both the clinical and the laboratory standpoint. We agree with these workers that the administration of this treatment should be confined to that institution until its merits and dangers have been completely evaluated.

The purpose of this paper is to present a critical review of the published reports and to comment on certain aspects of the problems involved.

REVIEW OF PUBLISHED REPORTS

As a result of the symposium at Mount Sinai Hospital, a series of nine papers[3] was published in August, 1940, which presents the most recent data on massive arsenotherapy in early syphilis (the five-day treatment of early syphilis).

Method of Treatment.—From 1933 to 1938, neoarsphenamin was used in treating ninety-three patients with primary or secondary syphilis by the five-day method. A freshly prepared solution, consisting of 0.1 gram neoarsphenamin dissolved in 100 cubic centimeters of 5 per cent glucose, was administered by intravenous drip at the rate of

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TABLE 1.—*Therapeutic Results Obtained With Neoarsphenamin*

Patients	Duration of Follow-up Study	Number of Patients Treated	Negative Serologic Reactions; Clinical Cures		Failures: * Clinical or Serologic Relapse	Maximum Per Cent of Failure
1933 group	6 years	15	13	86%	2	13.4
1937 group	2 years	78	71	91%	7	9.0
Total		93	84	90.3%	9	9.7

* Including doubtful seropositive results.

3 cubic centimeters per minute for ten hours a day during five successive days. Thus, the total dose of neoarsphenamin was 4 to 4.5 grams. Because of a death from hemorrhagic encephalitis following this treatment, mapharsen, being considered a less toxic drug, was substituted for neoarsphenamin in 1938. With the exception of one, all patients treated were males.

Two series of patients were treated with neoarsphenamin, one group in 1933 and the other in 1937. The former was followed for six and the latter for two years. Table 1 shows the therapeutic results obtained with neoarsphenamin.

All the patients who were lost, from observation, are included in the percentage of maximum failure, and those in whom there was any doubt as to the therapeutic results were classified as failures. Even with this rigid analysis, the percentage of clinical cures was high, *i. e.*, 90.3 per cent.

Toxic Effects from Neoarsphenamin.—Many toxic reactions were encountered in the patients treated with neoarsphenamin. The untoward effects from both neoarsphenamin and mapharsen as given by Chargin are listed in Table 2.

The incidence of primary and secondary fever, transient erythema, jaundice, and peripheral neuritis was rather high. In the primary, or Herxheimer fever, the temperature rose sharply, averaging 102 degrees Fahrenheit on the first day of treatment; it usually subsided to normal by the next morning. The highest temperature noted in primary fever was 105 degrees Fahrenheit, and the longest duration was four days. The secondary fever appeared toward the end of the treatment period; the temperature averaged 102.8 degrees Fahrenheit for four days, the highest temperature was 105.4 degrees Fahrenheit and the longest duration ten days. In some cases the secondary fever was accompanied by erythema. The toxicoderma was mild, of short duration and did not sensitize the patient to the drug. The high percentage of this reaction is noteworthy. The incidence of peripheral neuritis (35 per cent) in patients treated with neoarsphenamin was exceedingly high, and while in most cases the reaction was mild it lasted for four to six months in several instances.

It is obvious from Table 2 that the percentage of toxic reactions caused by mapharsen was much smaller than that brought about by neoarsphenamin. Mapharsen, therefore, may be considered a safe drug for this purpose.

Treatment with Mapharsen.—As previously stated, treatment with mapharsen was begun in the fall of 1938. At first, 10 per cent of the dose of neoarsphenamin, or 400 milligrams, was given. Because of the low toxicity, the dose was slowly increased to 1,200 milligrams. The patients treated were divided into two groups. *Group A* consisted of 157 patients, who received less than 1,200 milligrams of mapharsen and were followed for eighteen months. Of these, twenty-four received

TABLE 2.—*Untoward Effects from Neoarsphenamin and Mapharsen*

	Neoarsphenamin		Mapharsen	
	Number	Per Cent	Number	Per Cent
Total treatment courses 399 treatment cases	111		288	
Primary fever	69	62	116	40
Secondary fever	71	64	36	12
Toxicoderma	50	45	33	11
Dermatitis exfoliativa	1	0.9	0	0
Blood dyscrasias	0	0	0	0
Renal damage	0	0	0	0
Jaundice	4	3.6	2	0.7
Peripheral neuritis	39	35	5	1.6
Cerebral symptoms	2	1.8	3	1.04
Hemorrhagic encephalitis	(1)	(0.9)	(1)	(0.34)
Single convulsions	(1)	(0.9)	(1)	(0.34)
Disorientation	(0)	(0)	(1)	(0.34)
Fatality	1	0.9	0	0

less than 600 milligrams; thirty received approximately 700 milligrams; twenty-seven, 800 milligrams; forty-nine, 1,000 milligrams; and twenty-seven, 1,100 milligrams. *Group B* consisted of one hundred patients, who received 1,200 milligrams of mapharsen and were followed for only six months. An evaluation of the therapeutic results obtained in Group A showed satisfactory results in 72 per cent. This number included all those who were classified as failures. The period of observation in Group B has been too short to evaluate the therapeutic results. To the present time the therapeutic results from mapharsen appear inferior to those from neoarsphenamin, although the toxicity of the former is definitely less than that of the latter.

COMMENT

The proponents of massive arsenotherapy in early syphilis set forth its advantages as follows:

1. By this method the infectious lesions of early syphilis are rapidly sterilized. Treponema pallida disappear within twenty-four to forty-eight hours, and the lesions remain free of spirochetes and heal rapidly.

2. Only five days are required to complete the course of treatment. Thus, the prolonged treatment over a period of two or three years, necessitated by the present methods of multiple injections, is eliminated.

3. All patients who are placed under treatment complete their course. In contrast, 20 to 80 per cent of the patients treated by the usual methods disappear from observation before therapy is completed.

4. The percentage of satisfactory therapeutic results is as great, or greater, than in the methods now in use.

5. A massive sterilizing dose of a spirocheticide accomplishes the primary aim of Ehrlich.

6. Administration of massive doses of the arsphenamins by the continuous drip method eliminates the phenomenon of speed shock.

7. Serious toxic reactions may be avoided by substituting mapharsen for neoarsphenamin.

The disadvantages of the massive arsenotherapy in early syphilis may be stated as follows:

1. The five-day treatment is still in the experimental stage. It should, therefore, be thoroughly investigated in hospitals equipped to carry out the procedure and to do proper follow-up studies before it is submitted for general application by practicing physicians and by clinics. A period of several years will probably be required to accomplish this.

2. It is a hospital procedure and entails considerable expense.

3. Sufficient time has not elapsed to evaluate the final therapeutic results and the toxic end-effects.

4. Neoarsphenamin is too toxic to be practical for application by this method.

5. Mapharsen is definitely less toxic than neoarsphenamin and may be used in its place. However, it has been employed for too short a time to determine its therapeutic value. To date, the therapeutic results with mapharsen have not been as satisfactory as those reported with the use of neoarsphenamin.

6. This method has been employed only in males with early syphilis. Therefore, no data are available as to its value in the treatment of early syphilis in females, of latent syphilis, or of the numerous manifestations in late syphilis.

Two other points mentioned in these publications[3] warrant further discussion. The original investigators state that 4 to 4.5 grams of neoarsphenamin may be given by the massive dose method in five days, while three months are required for this dosage by the usual methods of antisyphilitic treatment. I wish to point out that by the usual methods of treatment of early syphilis we administer 4.35 grams of neoarsphenamin in six weeks; in some clinics an even higher dosage is used. I am certain that, if it seemed advisable, this dosage could safely be increased further by the use of the multiple injection method.

Secondly, I disagree with the statement that the incidence of hemorrhagic encephalitis in the cases reported,[3] namely, two in 350 with death in one, is not excessive. The authors quote Cole[4] as reporting that the incidence of deaths due to hemorrhagic encephalitis in syphilis treated by the usual methods is one in 200 cases. Moore pointed out that hemorrhagic encephalitis was noted at Johns Hopkins Hospital in only one of 15,000 cases under treatment. Stokes[5] stated that a mortality rate from all causes of one in 15,000 to 35,000 injections of the arsphenamins may be considered good technical performance. Under the most favorable conditions the unavoidable risk of antisyphilitic treatment is much less. Since hemorrhagic encephalitis is responsible for 50 per cent of all deaths due to the arsphenamins, fatalities as a result of this reaction are obviously rare. This finding coincides with the experience we have had at the University of California Clinic. During the past fifteen years we have encountered death from hemorrhagic encephalitis as a result of treatment with the arsphenamins in only one case.

CONCLUSIONS

Massive arsenotherapy of syphilis is at present entirely experimental. Many years of investigation are required before its true value in the treatment of syphilis can be determined. It has been tried only in the primary and secondary stages of syphilis in the male.

This method of antisyphilitic treatment should not be used by physicians or clinics in general. It should be employed only in institutions equipped to carry out the technique of the procedure and, what is more important, to follow the patients for a sufficient period of time to evaluate the therapeutic effects.

Much work must be done both clinically and on experimental animals before the most effective dose of the drug and the most advantageous period of treatment can be determined.

The five-day treatment of syphilis opens up a new avenue of approach to the control of early syphilis, and is an important contribution to the study of the problem of antisyphilitic therapy.

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RECURRENT LYMPHANGITIS*

REPORT OF A CASE WITH UNUSUAL FEATURES

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THE subject of lymphangitis is given scant treatment in textbooks on dermatology. In those on internal medicine and surgery it receives usually a few more lines, but in none at our disposal have we been able to find a detailed description of the topic under consideration. Recurrent lymphangitis, as the term is used here, is undoubtedly a clinical and biologic entity. Its cardinal characteristics are a diffuse, occasionally streaked erythema, involving any part of the body, but showing sites of predilection, and most commonly seen on the lower extremities. This erythema may cover a patch the size of a silver coin or completely involve two extremities or more; usually it is associated with some edema. Hence, it frequently has been referred to as chronic or recurrent erysipelas. During an attack the erythema frequently, although not always, is associated with palpable enlargement of the satellite glands. In very mild infections there may be no demonstrable rise of temperature, but usually there is a fever of 102 to 103 degrees Fahrenheit and we have seen an occasional rise to 106 degrees Fahrenheit. This syndrome might be simulated by other types of infection, but its most distinctive characteristic is its self-limited course, which varies from two to six days. Such an attack recurs every week or two or at intervals of several months, always shows the same characteristics, and in due time results in considerable thickening of the tissues and a veritable elephantiasis. Gans,[1] while he does not sharply depicture this syndrome, gives an accurate description of its histopathology in his chapter on early and late elephantiasis. This clinical syndrome is a reasonably common one, although probably not clearly recognized by the average practitioner; and, if personal experience can be relied upon, not even by all dermatologists. The case reported here, however, has shown some unusual features, observed by us in only this one patient out of a total of more than thirty.

REPORT OF CASE

B. A., a man, aged thirty-three years, when first seen, in 1936, came with the history that the first symptoms were noticed ten years before; the erythema first was noticed on the inside of one foot. At that time a definite diagnosis of dermatophytosis of the feet was made elsewhere. While we could not demonstrate the mycotic organism during the time he was under our care, we believe we can readily agree with that diagnosis since it is a very common mode of development. The attacks since then occurred at intervals of about two weeks, and have involved both legs, causing considerable thickening. Six years after the beginning of the process on the legs there was involvement of both hands which also showed considerable enlargement, although less than the legs. For several years prior to consultation with us he had developed an eruption with vesiculation, oozing, crusting, scaling, fissuring—in brief, all the characteristics of a severe dermatitis. The case was unique in that this dermatitis, which involved almost the entire skin, coincided with the febrile attacks. As the patient noted his recurrence of local erythema and systemic symptoms, the dermatitis became severe and subsided as promptly as the other acute symptoms. During several years of observation he also showed marked sensitiveness to soap, turpentine, gasoline, paint, and various other substances Trichophytin tests were repeatedly positive. An attempt to treat him with sulfanilamide showed marked sensitiveness to ten grains three times daily, and produced marked photosensitiveness for a period of time. He has now been free from acute exacerbations for about one and one-half years. A residual induration of the tissues of the hands and feet constitute some impediment, but he is able to do some regular work where formerly he was totally disabled.

COMMENT ON CASE

It is the first case we have observed in which an eczematoid eruption was definitely a part of the syndrome of recurrent lymphangitis. The eruption was always synchronous with the febrile attack, indicating an etiologic relationship. Previous studies of our own and those of other observers point to the streptococcus or possibly to a mixed infection in the lymphatics as the cause of recurrent lymphangitis. Therefore, this case adds marked evidence to the conception that a focus of pyogenic infection can play at least a part in the production of an eczema. We are not unmindful, however, of the complex interplay of such an infection with the trichophyton, external irritation, and possibly some associated systemic abnormality, which Wise [2] has so beautifully emphasized in regard to vesicular eruptions of the hands and feet. It is evident that the patient's skin had undergone an allergic change, as shown by his hypersensitiveness to banal external irritants, to sulfanilamide with its ready production of photosensitiveness, and his very active response to trichophytin. Whatever the exact mechanism, there is no doubt that activity of the infection focus in the lymphatics acted as the precipitating cause, as the match, as it were, that produced the explosion.

We hope this case will serve to call particular attention to the syndrome of recurrent lymphangitis, to the end that its early recognition, on which depends much of its successful treatment, may penetrate wider medical circles, especially the general field. Long duration does not make the prognosis hopeless, however, as this case illustrates.

* Read before the Section on Dermatology and Syphilology at the seventieth annual session of the California Medical Association, Del Monte, May 5–8, 1941.

GENERAL COMMENT

Nearly thirty-five years ago one of the writers became specially interested in the problem under discussion as a clinical curiosity. This came about as the result of this syndrome's presence in a personal friend, who at that time consulted a large number of physicians, including several with the most famous names of that period. All efforts at treatment proved vain, however, and the attacks occurred without abatement for many years. The usual elephantiasic enlargement resulted, for which some relief was given by surgical interference. He is, today, a man of about sixty years, and while he has had no active attacks for a number of years, they have proved a very marked handicap for a good share of his active life. In retrospect, it may be said that the problem was not understood and, hence, efforts at treatment were misdirected. Since then the same writer (W. H. G.)[3] retained his interest, and in 1930 reported his observations on seventeen patients. He has had no occasion to change his opinion as reported at that time, although he has since had the opportunity to observe and treat more than thirty such patients. Since the advent of sulfanilamide we have tried it in three cases, but so far as we could determine, it was of no value. We have not tried any other drugs in the sulfonamide group.

It is evident that whatever term is applied to this syndrome, we are dealing with a lymphangitis; even if we look upon it as an erysipelas, histologically it is primarily a disease of the lymphatics. The exact mechanism involved, however, is not so readily determined. McGlasson[4] looked upon it as a streptococcus infection of the lymphatics, a fungous infection by its injury to the skin, furnishing an atrium for infection. Amoss[5] also looked upon it as a streptococcal infection. It must be admitted that the syndrome is most commonly seen on the legs following a siege of dermatomycosis. Traub[6-7] and Sulzberger[8] have been satisfactory results from special attention to treatment of the mycotic infection. The former, therefore, is inclined to look upon it as a trichophytid. The latter, after much theoretical discussion of allergy and immunity, remains undecided as to the mechanism, but evidently also leans to a trichophytid. Juarez[9] and Logefeil[10] want the term "tropical" added, although their cases are exact replicas of our syndrome, and they look upon it as streptococcal lymphangitis.

Our own belief is that the syndrome is always caused by the streptococcus and occasionally by a mixed infection with the staphylococcus. In the past we have had the opportunity to study sections of these cases and were able to find streptococci in the lymphatics much as in erysipelas. While we admit the very frequent association of a fungous infection with this syndrome, we believe that erosions and fissures produced by the mycotic infection simply act as a portal of entry for the streptococcus. This belief is further supported by the frequently complete absence of any clinical evidence of fungous infection of the skin, although these attacks will take place over a period of many years. In fact, it is sometimes difficult to escape the feeling that the pyococcal infection, with its resultant febrile attacks, has altered the immunity mechanism in such a manner as to free the patient from any clinical evidence of the mycosis. Above all, however, we are supported in our theory by the observation of cases in which a fungous infection did not come into question at any time. This very same syndrome may be found on other parts of the body. It is seen not uncommonly on the face, where fissures about the alae nasi and the corners of the lids may act as the atria. Here it is spoken of as solid edema when the changes of fibrosis become sufficiently evident. We have seen a case in which a fissure of the anus has acted as an atrium, another in which the streptococcus was introduced by the sting of a wasp on the back of the neck. One case under our observation was produced by a horse's bite, with injury to the underlying bone; this latter was the only case which resisted all efforts at treatment. It should be noted that, while the term "chronic erysipelas" may not be a misnomer, it is not a true erysipelas in the accepted sense of the term. A change in the patient's immunity has taken place, confining the activity of germs to a restricted area of the lymphatic bed and from there they act much like a focus of infection in the tonsils or teeth. In our observation, acute exacerbations are usually brought about by trauma, exposure, overwork, exhaustion, or improper hygiene.

IN CONCLUSION

A case of recurrent lymphangitis with unusual manifestations is reported. The extensive involvement of the lymphatics and the associated, almost universal dermatitis, with the characteristics of an eczema always appearing and disappearing synchronously with a febrile attack, make it unique in our experience. The subject of recurrent lymphangitis is reviewed and our opinion as to its pathological mechanism is discussed.

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CLINICAL NOTES AND CASE REPORTS

INTRAVENOUS THERAPY

DESCRIPTION OF INTRAVENOUS OPERATING TABLE

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THE apparatus herein described, and shown in the accompanying illustrations, is an intravenous operating table for use in administering all types of intravenous medication into the antecubital veins.

Its method of operation is as follows: The patient's arm is placed upon the table, with the upper arm in the tourniquet "V" and the wrist secured by the strap. The surgeon then presses down on the foot treadle until the veins are distended, and after cleaning the antecubital space with alcohol, inserts the needle into the vein; he then releases the foot treadle and proceeds to inject the medicament. Thus, with both hands free to manipulate the syringe and needle, the danger of injecting subcutaneously is minimized.

Basically, it is a foot-operated tourniquet that may be raised or lowered for different circumstances, or may be tilted to the proper angle. It can be used at the bedside, in the operating room, or in the office.

Fig. 1.—Photograph of operating table. Operator has depressed the foot treadle, wrapping tourniquet around the patient's arm. Physician about to insert needle in vein.

It is especially adaptable for giving intravenous anesthesia in that it is often necessary to give repeated doses in long operations.

Also it should prove convenient in luetic clinics

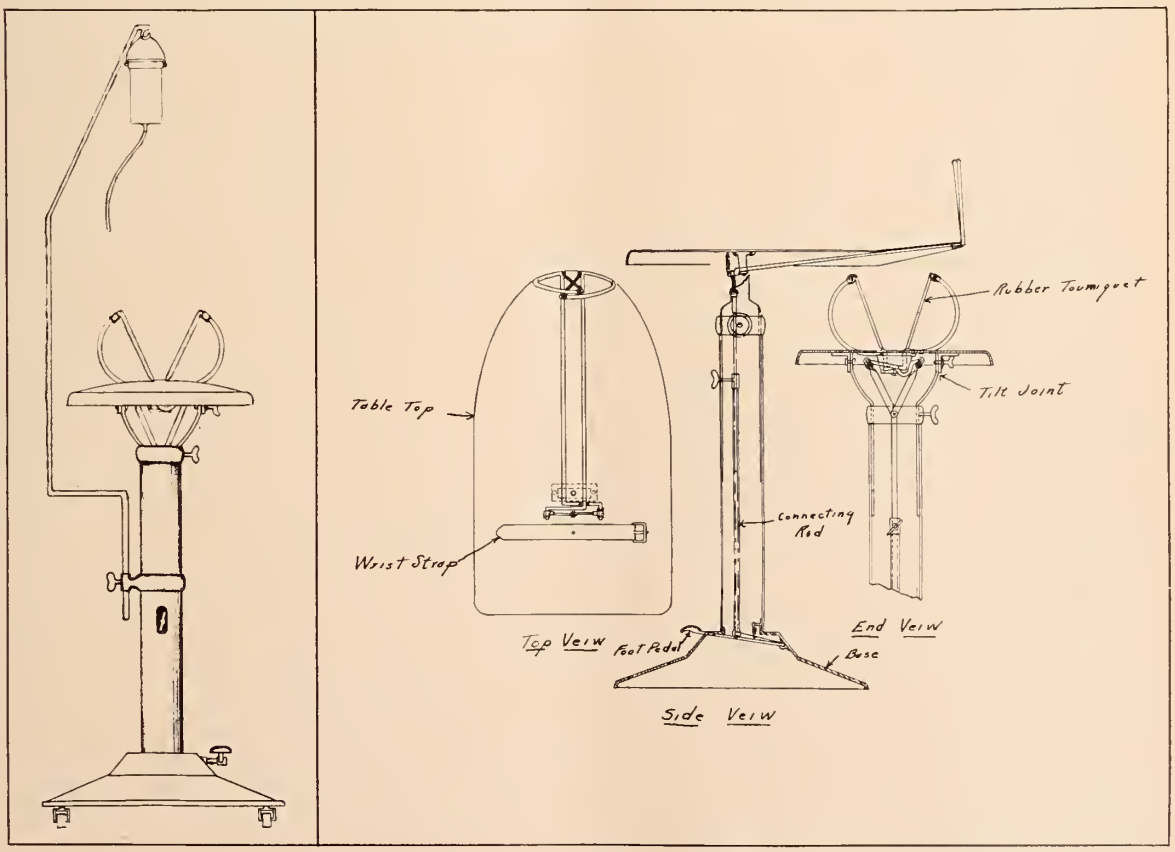

Fig. 2 Fig. 3

Fig. 2.—End view of operating table, showing support for container of saline or glucose solution.
Fig. 3.—Detailed views of operating table, showing working parts.

where large numbers of patients are given intravenous neoarsphenamin daily.

In doing blood transfusions two tables are used, one for the donor and one for the recipinet. The treadle control of the tourniquet around the donor's arm may be regulated so that the arterial blood supply comes through freely at intermittent periods.

At the present time most physicians are doing a great deal of intravenous therapy in their offices and, therefore, can appreciate the table in this routine work.

450 Sutter Street.

HIPPOCRATES' APHORISMS*

Moses Scholtz, M. D.
Arcadia

Section Seven (Continued)

14. Stupor or delirium,
From a blow on the head,
Is a dangerous symptom
To guard against and dread.

15. Blood-spitting leads
To spitting pus,
And oft to a state
Tuberculous.

16. Diarrhea and phthisis
From pus-spit arise;
But, if the sputum stops,
The patient dies.

17. Inflammation of the liver,
Followed by hiccough,
Threatens to carry
The sufferer off.

18. Fits, set upon
A stupor-state,
Forecast an end
Unfortunate.

19. When erysipelas sets in
On a wound of the cranium,
With a bone open and exposed,
The sick is likely to succumb.

20. When gangrene or suppuration
Occur in erysipelas,
Between Scylla and Charybdis
The sick shall have to pass.

21. When a strong pulsation of a wound
Brings on a hemorrhage,
It is a solid indication
That the sickness's in a danger-stage.

22. A protracted pain
Of abdomen,
Followed by pus,
Is a dangerous omen.

23. When dysentery does ensue
Upon unmixed alvine discharges,
Great dangers for the sick accrue.

24. If, in a case of fractured skull,
With an involvement of the brain,
Delirium does intervene,
The treatment's apt to be in vain.

25. Convulsions, following
A severe purge,
Prepare the way
To the patient's dirge.

26. With severe pains
In the abdomen,
Cold extremities
Are a bad omen.

27. Tenesmus during
A pregnant state,
May a miscarriage
Accelerate.

28. A piece of cartilage,
Nerve or bone,
When once cut off,
Can't grow into one.

29. Incipient edema
Is easily controlled,
If heavy diarrhea
Sets in and keeps its hold.

30. With frothy fluxes
In diarrheal cases,
Seep serous exudations
From the cranial spaces.

31. In fever, if the urine throws
A farinaceous sediment,
It is a sign the illness
Will be a long event.

32. When urine flows thin at first,
And bile's precipitated,
An acute type of the disease
Is thereby indicated.

33. If urine is divided in two parts:
A clear one and a thick,
It is an indication
That the man is very sick.

34. When bubbles show in the urine,
The kidneys are in disrepair;
It also carries a suggestion
That 'twill be a long affair.

35. When urine-scum is found
Both fat and copious,
An acute kidney-lesion
Becomes quite obvious.

36. When these symptoms from the kidneys
Merge with spinal muscles-pain,
An abscess forms outward; but with pains inside,
The abscess will inward drain.

413 Longden Avenue.

(To be concluded)

* For other aphorisms, see California and Western Medicine, March 1940, page 125; April 1940, page 179; May 1940, page 231; July 1940, page 35; August 1940, page 85; September 1940, page 130; December 1940, page 272; January 1941, page 27; February 1941, page 82; March 1941, page 124; April 1941, page 229; July 1941, page 35; September 1941, page 140; October 1941, page 204.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

HENRY S. ROGERS, M.D.....President
WILLIAM R. MOLONY, SR., M.D.....President-Elect
LOWELL S. GOIN, M.D.....Speaker
PHILIP K. GILMAN, M.D.....Council Chairman
GEORGE H. KRESS, M.D.....Sec'y-Treas. and Editor
JOHN HUNTON.....Executive Secretary

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Russel V. Lee, Palo Alto.

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Russel V. Lee, Palo Alto.
Albert J. Scholl, Los Angeles.
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William H. Goeckerman, Los Angeles.

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L. G. Hunnicutt, Pasadena.
George W. Walker, Fresno.

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William S. Kiskadden, Los Angeles.

Neuropsychiatry:
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Olga Bridgman, San Francisco.

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Urology:
Lewis Michelson, San Francisco.
Albert J. Scholl, Los Angeles.

Pharmacology:
Chauncey D. Leake, San Francisco.
Clinton H. Thienes, Los Angeles.

† For complete roster of officers, see advertising pages 2, 4, and 6.

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COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION

Minutes of the Two Hundred Ninety-Sixth (296th) Meeting of the Council of the California Medical Association*

Meeting was called to order in the headquarters building of the Los Angeles County Medical Association at Los Angeles, on Sunday, October 26, 1941, at 9:30 a. m.

1. Roll Call.

Present: Councilors Henry S. Rogers, William R. Molony, Lowell S. Goin, E. Earl Moody, Elbridge J. Best, Dewey R. Powell, Sam J. McClendon, Edward B. Dewey, George D. Maner, Louis A. Packard, Axcel E. Anderson, R. Stanley Kneeshaw, Frank R. Makinson, Frank A. MacDonald, and George H. Kress, Secretary-Treasurer.

Absent: Councilors Harry H. Wilson, Calvert L. Emmons (out of state), John W. Cline, John W. Green (out of state), and Philip K. Gilman, Chairman. (Captain Philip K. Gilman was not able to be present because he was on special Navy duty in Washington, D. C.)

Present by invitation: E. Vincent Askey, Vice-Speaker; John Hunton, Executive Secretary; Hartley F. Peart, Legal Counsel; and Mr. Ben Read, Secretary, California Public Health League.

2. Minutes.

Minutes of the 295th meeting, held in San Francisco on Sunday, August 10, 1941, were approved. (Abstract was printed in CALIFORNIA AND WESTERN MEDICINE, September, 1941, on page 141.)

3. Membership.

(*a*) A report of membership was submitted and placed on file. (Total members who have paid 1941 dues, 6,747; total number of new members in 1941 included in the above, 405; number of 1940 members who have not paid 1941 dues to date, 286.)

(*b*) A list of active members whose 1941 dues were paid subsequent to the last meeting of the Council on August 10, 1941, to number of forty-nine, was submitted. Upon motion duly made and seconded, their active membership for the year 1941 was reëstablished.

(*c*) Upon motion duly made and seconded, it was voted that Minnie A. Seavey, M. D., a member of the Sacramento Society for Medical Improvement, and a retired

*Reports referred to in minutes are on file in the headquarters office of the Association.

member of the California Medical Association, be recommended for affiliate fellowship in the American Medical Association.

(*d*) Executive Secretary Hunton presented a form of *membership card* for possible use in 1942 in lieu of the certificate which has been used during recent years. After discussion, upon motion by Dewey, seconded by MacDonald, it was voted to approve the membership card for 1942.

(*e*) Report was made that Frank McManus, M. D., a retired member, had taken up active membership in the San Mateo County Medical Society.

4. **Financial.**

(*a*) Financial reports as submitted were accepted and placed on file.

(*b*) Report was made by the special *Committee on Possible Redistribution of Reserve Funds* of the California Medical Association (references: minutes of August 10th Council meeting, September, 1941, CALIFORNIA AND WESTERN MEDICINE, page 142, item 4 (b)). It was voted that the submitted recommendations to distribute certain funds among a group of banks listed be approved.

(*c*) Statements for legal services rendered in connection with certain work having to do with the protection of the interests of scientific medicine were presented. After discussion, it was voted that the bills submitted be paid.

(*d*) A letter dated October 20th, received from the *California Academy of Medicine*, was presented, relative to participation by the California Medical Association in the payment of part of an honorarium to a guest speaker who would be available for a limited number of appearances before county medical societies.

It was stated that the Committee on Postgraduate Activities of the State Association felt that its budget would not permit participation in the proposed plan. The decision of the Postgraduate Committee was concurred in by the Council.

5. **County Society: Request for a Duplicate Charter.**

The Stanislaus County Medical Society having lost its charter, and a request having been made that a duplicate be issued, the State Association Secretary was instructed to secure additional information from the Society.

6. **Committee on Public Health Education.**

(*a*) *Exhibits at State and County Fairs.*—The Committee on Public Health Education made report through its chairman, Frank R. Makinson. Concerning public health exhibits at state and county fairs, Doctor Makinson commented on the value of state and county fairs as excellent media for the dissemination of knowledge concerning the activities of scientific medicine in relation to public health.

On motion by Makinson, seconded by Powell, it was voted that, until otherwise ordered by the Council, the interest of the Herzstein Bequest Fund be earmarked for use in measures designed to combat quackery, by promotion of public health exhibits in county fairs, through purchase of necessary display and film equipment, transportation and care of equipment, transportation and cost of authorized attendants, and other means sanctioned by the Council or Executive Committee.

(*b*) *Basic Science Initiative.*—Report was made by Councilor Makinson concerning the costs involved to date, in connection with the printing and circularization of the petitions designed to place a basic science initiative on the ballot of the next state election. In the discussion which followed, it was brought out that petitions containing a total of some 39,000 names were on file. These petitions contained the names of 25,000 citizens residing in the southern section of California, the remaining 14,000 names being of citizens residing in the northern section of the state.

Statement was made that, in order to put the initiative petition across in good form, experience has shown that at least 150,000 signatures should be secured from Los Angeles County. The average number of names on petitions thus far received was sixty-three.

It is planned to make a check of component county societies about November 15, and about the same time to request the coöperation of the members of the Woman's Auxiliary to the California Medical Association. It was pointed out that a total of about 300,000 signatures would be necessary to insure the 212,000 valid signatures needed; and that if this number is not secured through the medical profession and affiliated organizations, it will be necessary later to employ commercial circulators, at an expense of something like ten cents per name.

The importance of observing the rules in regard to petitions was pointed out. In each county, the County Clerk or the Registrar of Voters has the authority to determine the validity of petitions presented.

Upon motion duly made and seconded, it was voted that the sum of $2,000 be allocated from the General Fund to cover contemplated expenditures.

7. **California and Western Medicine.**

(*a*) *New Printer for the Official Journal.*—Report was made by Executive Secretary Hunton that on and after January 1, 1942, CALIFORNIA AND WESTERN MEDICINE would be printed in Los Angeles instead of San Francisco (Wolfer Printing Company, Inc.), this action being taken in accordance with authority granted by the Council at its 294th meeting (item 8, on page 38 of the July CALIFORNIA AND WESTERN MEDICINE) and at the 295th meeting (item 19, on page 144 of the September issue).

Letters from The James H. Barry Company, present printers of CALIFORNIA AND WESTERN MEDICINE, were presented and ordered placed in the files.

Announcement was made that an advertising representative for the southern section of the State had been engaged.

(*b*) The resignation of Packard Thurber, M. D., one of the members representing industrial medicine and surgery on the editorial board, was received and accepted. Dr. John D. Gillis of Los Angeles was elected to fill the vacancy.

8. **Recess—Executive Committee Meeting.**

At this point a recess was called to permit the Executive Committee of the California Medical Association to hold a meeting.

9. **Medical Services Rendered by Hospitalization Groups.**

(a) The *scope of medical services rendered by hospitalization groups and organizations* came up for discussion. (References: House of Delegates Resolution 14, June CALIFORNIA AND WESTERN MEDICINE, page 340; Council minutes, September CALIFORNIA AND WESTERN MEDICINE, item 7, page 142).

(b) *"Statement of Association Policy."*—Correspondence with representatives of the Pacific Roentgen Society was presented. After discussion, upon motion by Goin, seconded by Anderson, it was voted that the following restatement of policy of the California Medical Association in relation to medical services involved in hospitalization plans be made a matter of record, this statement being as follows:

HOSPITAL SERVICE INSURANCE

A Statement of Policy Issued by the California Medical Association, October 26, 1941

The California Medical Association has consistently endorsed the principle of hospital service insurance and, upon request, the Council of the California Medical Association has given its approval to some or all of the activities of local hospitalization associations. The California Medical Association recommends only those hospital contracts which provide straight hospital services. It does not give and it never has given approval to any contracts which provide

medical benefits or services as a part of hospital services. It does not object to the provisions of limited diagnostic medical services (x-ray and laboratory) along with hospital benefits, provided that these are arranged for on some ethical and legal basis such as reimbursement or indemnification. The following points are, therefore, emphasized:

1. The California Medical Association approves hospital service insurance associations which issue straight hospital service policies (for example, the hospital contract issued by Hospital Service of California and the Associated Hospital Service of Southern California in conjunction with California Physicians' Service).

2. It does not recommend any hospitalization contract which provides diagnostic x-ray, laboratory or other medical services as hospital benefits. These are medical benefits and may only be issued on an indemnification or medical service basis.

3. When hospital service insurance associations issue hospital service contracts which include indemnification for diagnostic medical services, it is desirable that such be specified in the description of the contract (for example: Hospital service contract and limited professional service contract). Further, it is desirable that the association issuing such contracts make specific arrangements whereby the fees for radiology or pathology are payable to the physician rendering those services, or jointly to the physician and subscriber (in which case the subscriber can endorse the check over to the physician rendering the service). In this manner the hospitalization association will be complying with the letter as well as the spirit of indemnification.

4. The California Medical Association emphasizes that it does not approve or endorse any hospital service contracts which purport to provide any medical services as a part of hospital services, nor can it countenance the issuance by any hospitalization association of advertising literature which does not indicate that payment for medical services is being made to physicians rendering such services. It is important for the welfare of the public, the hospitals, and the medical profession that a clear distinction be made between hospital service and medical service in any and all of these hospitalization insurance contracts.

(c) *Schedule of X-Ray Charges for Selective Service Work.*—Correspondence between Dr. L. Henry Garland, for the Pacific Roentgen Society and General J. O Donovan, State Director of Selective Service for California was presented concerning schedules of costs for x-ray charges, the same being attached to a letter dated October 9.

After discussion, upon motion by Goin, seconded by Kneeshaw, it was voted that the schedule of charges for x-ray work, as submitted, be approved.

(d) *Charges for Electrocardiograms.*—Discussion was had concerning an equitable charge for electrocardiograms, the opinions of some cardiologists being submitted. It was voted that this subject be further investigated, and after adequate information has been received from members of the profession who are directly interested, the Chairman of the Executive Committee be empowered to transmit recommendations to the State Director of Selective Service.

(e) *Charges for X-Ray Work, in Relation to California Industrial Commission.*—A communication having date of October 16, received from Dr. L. Henry Garland in re industrial accident fee schedules, was read. After discussion, upon motion by Makinson, seconded by Anderson, it was voted that further investigation be made and when adequate information has been secured the Executive Committee be empowered to act and to transmit its recommendations to the Commission. It was agreed that the Council Chairman should promptly contact members of the Special Committee on Insurance Fee Schedules (Doctors Morton R. Gibbons, Sr., San Francisco; Carl Hoag, San Francisco; and Frank A. MacDonald, Sacramento) in regard to the issues involved.

10. Survey of California Medical Association Legal Department.

(a) The Special Committee to Survey the Legal Department of the California Medical Association (Doctors Philip K. Gilman, San Francisco; Henry S. Rogers, Petaluma; Frank R. Makinson, Oakland; and Elbridge J. Best, San Francisco) submitted a progress report through Acting Chairman Elbridge J. Best. On motion by Anderson, seconded by Moody, same was received and placed on file.

11. California State Compensation Insurance Fund: Some Testimonial Correspondence.

(a) *Presentation of Copies of Certain Letters and Action Taken Thereon.*—The attention of the Council was called to certain communications that had been circularized to members of the medical profession by the Wilshire Medical Laboratories of Los Angeles, as follows:

1. A photostatic copy of a letter bearing the signature of John C. Stirrat, Manager of the State Compensation Insurance Fund; and

2. An appeal that laboratory work needed for injured employees be sent to said laboratory.

After consideration of the same and other evidence, upon motion duly made and seconded, it was voted that the Council agreed that the manager of the State Compensation Insurance Fund has exhibited unwarranted favoritism in favor of said laboratory, thus discriminating against many equally or better qualified laboratories.

Further, the Council of the California Medical Association considers compliance with the suggestions contained in the photostatic copy of the letter dated August 22, 1941, and signed by the manager of the State Compensation Insurance Fund, to be beneath the dignity of the members of the California Medical Association.

The Council also expresses its unqualified disapproval of this campaign of solicitation by a state official on behalf of a private institution, ignoring as he has done, many competent, medically directed laboratories in Los Angeles and vicinity, in addition to the attempted use of political influence in relation to the medical care of the unfortunate victims of industrial accidents.

(b) *Instructions to Executive Committee to Call Attention of Certain State Officials to Pertinent Correspondence.*—After further discussion, on motion duly made and seconded, it was voted that the Executive Committee be directed by the Council, within fourteen days, to formulate a protest embodying the sentiments included in the aforesaid resolutions, and as brought out in the discussion on the evidence presented; and that copies of such protest be forwarded to His Excellency Governor Culbert Olson, Mr. John C. Stirrat, Manager of the State Compensation Insurance Fund, the Industrial Accident Commission, the State Compensation Insurance Fund, and other interested state agencies, such protest to have attached, copies of the photostat letters bearing the signature of Mr. Stirrat, and the two enclosures from the Wilshire Medical Laboratories; and, further, that the action taken by the Council be published in the editorial section of the next issue of California and Western Medicine.

12. Committee on Needy Members (Medical Benevolence.

(a) The special Committee on Needy Members (Drs. A. E. Anderson, chairman; Elizabeth Hohl, and Robert A. Peers), presented a progress report on plans whereby this new activity of the California Medical Association could be instituted to best advantage. Discussion was had concerning various means of conserving and increasing the fund which, by action of the House of Delegates at Del Monte in May, 1941, through the allocation of $1 from the State dues of each member, was brought into being. Considerable discussion took place concerning different forms of insurance annuities. It was agreed that this fund was in the nature of a trust and that before expenditures could be made therefrom it was most important that a proper financial set-up should be put into operation in the headquarters office. The suggestion was made that the Executive Secretary, upon whom would fall the special responsibility of executing financial instructions concerning the fund, should draft a plan of procedure, the same to be submitted to the Committee on Needy Members; and by that committee to be presented with other recommendations at the next meeting of the Council, at which time

it was hoped to place the fund in active operation. Upon motion by Packard, seconded by Moody, it was so voted.

13. Industrial Accident Commission Ruling 19 of Date of September 16, 1941.

(*a*) The recent ruling of the Industrial Accident Commission of the State of California (Reference: October CALIFORNIA AND WESTERN MEDICINE, page 171), was called to the attention of the Council through a letter dated October 13, 1941, received from Dr. Nelson J. Howard of San Francisco, in which criticism was made of the possible increase in paper work which might be demanded of physicians who are doing industrial work. Since the entire subject is still under consideration, the Council took no action.

14. County Society Committees on Medical Defense.

(*a*) A letter from the Chairman of the Association's standing Committee on Medical Defense, Dr. Nelson J. Howard, and dated October 13, 1941, was presented. The Committee called the Council's attention to the work it had been carrying on in efforts to induce component county societies to adopt suggestions concerning local Grievance Committees and other recommendations, and through which it was hoped a certain number of unwarranted malpractice suits might be prevented. The Committee requested the Council's approval of its action in asking such coöperation from the component county societies. Upon motion by MacDonald, seconded by Dewey, the Council voted such approval.

15. Concerning Pasteurization of All Milk.

(*a*) A progress report was made concerning the expressions of opinions received in questionnaire replies from the representatives of Certified Milk Commissions, regarding the need or desirability of pasteurizing all milk, inclusive of certified milk. (Reference: Item 30 of Council meeting of August 10, 1941.) This subject having been called to the attention of the Council by Doctor Emmons, who was absent, it was felt that the matter could be held over for consideration at the next Council meeting.

16. Legal Department: Reports.

General Counsel Hartley F. Peart reported on the following matters:

(a) *Survey of a County Hospital.*—The Council's attention was called to certain court actions in one of the California counties, in which some issues were involved of importance to the best interests of the public health, and of the advancement of scientific medicine.

(b) *Business and Professions Code: Reciprocity Amendment.*—Mr. Peart placed before the Council correspondence dealing with a possible attack on the constitutionality of this recent amendment to the Code.

(c) *Intercoast Hospitalization Insurance Association.*—A letter from Mr. D. B. Frantz, counsel for the Intercoast Association, was read requesting a ruling regarding payment for professional services in the administration of anesthetics. The Legal Counsel was authorized and directed to forward to Mr. Frantz a statement of the policy of the Association with reference to this matter this day adopted and to give a specific answer to the question presented, the letter and contents to be approved by the Chairman of the Council.

(d) *Retired Membership: Leaves of Absence.*—The General Counsel read his opinion to the Association, dated September 19, 1941, setting forth the conditions under which retired membership is now granted by county societies, this Association, and the American Medical Association. The report was ordered filed.

Questions of leaves of absence by county societies were also submitted. Legal Counsel will submit to the Council drafts of appropriate amendments.

(e) *Industrial Accident Commission: Rule Concerning Medical Records.*—Mr. Peart read his opinion to the Association, dated September 24, 1941, and discussed certain phases of the rule in response to questions of various members of the Council.

(f) *Social Security Taxes—Old Age Taxes.*—A report was presented covering old age taxes paid on demand of the Commissioner of Internal Revenue ruling holding that the Association was entitled to exemption. Refund claim for $468.01 was denied November 1, 1939. Mr. Peart pointed out that suit must be commenced before November 20, 1941. Mr. Peart advised that, in view of recent decisions upholding the right of the Government to set aside an existing exemption, it would be inadvisable to sue.

On motion duly made, seconded and unanimously carried, the report of the attorney was approved and he was instructed not to commence action on this refund claim.

(g) *Unemployment Taxes.*—The Counsel then reported that the unemployment tax for the years 1936-1939 involved the sum of $1,266.06, for which refund claim was rejected August 31, 1940; that the Association had until August 30, 1942, within which to commence an action to recover these taxes; that the point involved in this matter was whether or not the councilors and officers of the Association were employees within the meaning of the Act, thereby bringing the total of the employees above eight for these years; that two District Court decisions had held that such unpaid officers were not employees and one District Court had held that unpaid officers were employees, and that action should, therefore, be deferred to await further court decisions.

On motion duly made, seconded and unanimously carried, the Legal Counsel's report was approved.

(h) *Tulare Community Hospital.*—The Legal Counsel called the attention of the Council to a projected community hospital at Tulare, Tulare County, California, and the request of members of the Association in that city for assistance in the organization of the hospital.

(i) *Federal Tax on Membership Dues.*—Mr. Peart read a copy of his opinion to Mr. John Hunton, Executive Secretary of the Association, dated October 16, 1941, advising that the recent amendments to the Internal Revenue Code do not change the law or impose a tax on admissions and dues of the members.

(j) *Malpractice.*—A brief report on events occurring in a component county medical society in connection with a malpractice action was submitted.

17. Date of Next Meeting of California Medical Association Council.

(*a*) The Association Secretary asked for instructions concerning the date of the *next meeting of the Council*, stating that, in accordance with past custom, the same could be a two-day session; one day being given over to a *meeting of the county secretaries*, and the other day to the Council meeting.

It was thought that Sunday might be a more convenient meeting day for many county society secretaries, especially since other county society officers also might find it then to be convenient to attend.

(*b*) It was agreed that the meeting on Saturday should be a Council meeting and that the meeting on Sunday, immediately succeeding, should be designated for the joint conference of county society secretaries and State Association officers and committees. The third week in January was suggested as a possible time. Upon motion duly made and seconded, the final decision as to date of the meeting was left to the Chairman of the Council.

18. Progress Reports of Special Committees.

(*a*) A progress report was submitted by the special *Committee on Pension Policies for Employees* (Edward N. Ewer (chairman), Junius B. Harris, Edward M. Pallette, Sr.), and it was stated therein that the entire subject

was still being studied. The progress report was received and placed on file.

(*b*) The *Committee on Hospitalization Subsidy* (John H. Shephard (chairman), Wayne E. Pollock, Neil J. Dau), made a progress report concerning the work it had carried on to date. This report was received and placed on file.

19. Evacuation and Other Plans for the Southwest Border of the United States.

(*a*) Attention was called by McClendon to the plans which had been formulated by authorities of Arizona, Mexico, New Mexico, and California, concerning the best means of caring for citizens living along the border lines of the states involved, in case certain international emergencies arose. Upon motion by McClendon, seconded by Packard, it was voted that the general plan to which the Arizona State Medical Society had already given approval, also receive the sanction of the Council of the California Medical Association, and that the chairman of the Special Coördinating Committee, Dr. Francis E. Toomey of San Diego be so notified.

20. Proposed Codification of Code of Ethics.

(*a*) The desirability of having a codification of rulings which had been handed down concerning the Principles of Ethics of the American Medical Association—which is also the Code of Ethics of the California Medical Association—was called to the attention of the Council by McClendon. After discussion of the different phases of the subject, upon motion by Packard, seconded by Kneeshaw, it was voted that the Chairman of the Council appoint a committee of three or five members to make a study of the subject, with instructions to bring in a report and recommendations to the Council, for subsequent consideration by the House of Delegates at the next annual session; the scope of such a report to take into consideration not only codification but interpretation of various ethical principles.

21. California Youth Correction Authority.

(*a*) The California Youth Correction Authority enacted at this year's session of the legislature, and now comprising Chapter I, Sections 1700-1783 of the Welfare Institution Code, was informally discussed by Rogers. President Rogers stated that an organization meeting of the State Panel on Nominations, of which the President of the California Medical Association is one, would be held on Monday, October 27, 1941, at which time he would call the attention of the four other members of the committee to the desirability of having at least one of the three members of the Authority be a physician, with a background to indicate his capacity to be of special service in the supervision of "preventive and corrective training and treatment for persons under twenty-three years of age, who at the time of apprehension were committed to municipal or superior courts."

22. Committee on Public Policy and Legislation.

Chairman Dwight Murray, not being present, the attention of the Council was called to some recommendations made by him:

(*a*) It was suggested that the *California State Federation of Labor* be contacted to learn what was the status of the proposed plan of that organization in re panels of physicians who are called upon to care for injuries and diseases coming under the jurisdiction of the Industrial Accident Commission. It was suggested that conferences with other interested groups were also desirable. The Chairman of the Council was requested to confer promptly with the special committee that was making a study of this problem (John W. Cline (chairman), Morton R. Gibbons, Sr., Nelson J. Howard, R. Stanley Kneeshaw, and John W. Green), in order to secure early action thereon.

(*b*) Chairman Murray called the attention of the medical profession of the state to the generous *coöperation which had been rendered by legislators* in the promotion of statutes designed to promote the best interests of public health and of scientific medicine, expressing the hope that physicians everywhere would feel free to thank their legislative representatives for the aid that had been so rendered, and to extend all possible courtesies.

(*c*) Attention was called to the *new law* (Reference: Chapter 573; Assembly Bill 690), *granting special traffic privileges to physicians* who were on emergency calls. Report was made on the design that had been drafted by the California Department of Motor Vehicles and which that state department had the authority to adopt. Attention was also called to the desirability of certain amendments to the recently enacted law designed to better safeguard the integrity and use of the emblem.

23. Rehabilitation Plans for Draftees Under the Selective Service Act.

(*a*) Attention was called to the proper interpretation of the statistics on so-called "physical defects" that were stated to be responsible for a large number of selectees being declared unfit for military service. It was felt that the widespread publicity concerning these figures—exploited as they were, without proper explanatory comment on why they existed, and outlines of rational ways and means whereby such deficiencies could be best eradicated—would lead many citizens to draw erroneous impressions concerning medical service standards. It was suggested that the Committee on Public Health Education and members of the profession, through the county medical societies, give this subject their early attention, and that proper publicity of the basic causes be promoted. In the discussion it was pointed out that the proposed rehabilitation program might be used by some, as a reason for the instituting of a compulsory health insurance system.

24. Association of Military Surgeons.

(*a*) The President of the Association was authorized to send a telegram to the Association of Military Surgeons in session at Louisville, suggesting that the next annual meeting of that organization be held in California.

25. Adjournment.

(*a*) Upon motion duly made and seconded, it was voted to adjourn. The adjournment was ordered made in memory of the late Dr. Howard Morrow, president of the California Medical Association in 1938, whose death occurred on Wednesday, October 22, 1941.

ELBRIDGE J. BEST, *Vice-Chairman.*
GEORGE H. KRESS, *Secretary.*

CALIFORNIA COMMITTEE ON MEDICAL PREPAREDNESS†

Selective Service Physicians Will Continue to Serve

The announcement made under Medical Preparedness in *The Journal,* October 18, page 1364, that a single physical examination for selective service registrants would be the procedure to be followed after January 1, 1942, was based on an official release from the National Headquarters of the Selective Service System. Subsequently, an announcement has been received to the effect that this origi-

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the chairman of the California Committee on Medical Preparedness. Charles A. Dukes, M. D., 426 Seventeenth Street, Oakland, is a member of the American Medical Association Committee on Medical Preparedness. Roster of county chairmen on Medical Preparedness appeared in CALIFORNIA AND WESTERN MEDICINE, August, 1940, on page 86.

nal release was premature and that a further statement will be made in the near future indicating the modifications that are to take place in the methods of examination.—*The Journal of the American Medical Association,* October 25, 1941.

* * *

Plans for Rehabilitation of Rejected Draftees*

In his press conference, October 10, President Roosevelt criticized the nation for permitting conditions which have left 50 per cent of its youth unfit mentally or physically for Army service, and inaugurated a program to "salvage" 200,000 of the 1,000,000 youths who have been rejected.

Under the salvage program the Federal Government will pay medical costs for treatment by local physicians of approximately 200,000 registrants whom local draft boards certify as susceptible of rehabilitation for Army service. The Army expects to accept virtually all of these 200,000 after they undergo treatment by family physicians or dentists at federal expense, Mr. Roosevelt said.

Describing the salvage program as only the initial objective, Mr. Roosevelt said that existence of conditions which permit so high a ratio of rejections is an indictment of America. He said he would launch a long-range program calling for coöperation of states, counties, cities, townships, and individuals to remedy the conditions which are the underlying cause of the bad situation. He released statistics collected by Selective Service Headquarters showing that approximately 1,000,000 men have been disqualified for Army service because of physical, mental, or educational conditions. This represents approximately 50 per cent of the total number of men examined. Mr. Roosevelt made it clear that he feared this ratio among men of draft age represented a fair index of the health conditions of all Americans.

The President read from a report presented by Brigadier General Lewis B. Hershey, Selective Service director, which declared that, of the 1,000,000 rejected, "about 200,000 can be completely rehabilitated and made available for general service in our armed forces. The remainder can be rehabilitated to perform only limited service or, because of mental, nervous, cardiovascular and pulmonary diseases and musculoskeletal defects are incapable of rehabilitation or even limited service and are, therefore, not being considered under the present rehabilitation program for Selective Service registrants," Hershey's report said.

"Our initial objective in this rehabilitation program will be the 200,000 registrants who can be completely rehabilitated and made available for general military service in the armed forces at a small cost and in a reasonably short time.

"Certain types of venereal diseases, operable hernias, deficiencies in vision and teeth, and other minor defects will be corrected in cases where the Army determines that the registrant will then be acceptable for general military service.

"The registrant will have the privilege of having the services performed by his family physician or dentist in his own community.

"The cost of this rehabilitation program will be borne by the Federal Government as a necessary part of our national defense program, and additional funds will be made available to the Selective Service System for this purpose."

Mr. Roosevelt was asked by what authority registrants could be compelled to undergo medical or dental treatment to prepare themselves physically for military service. He replied that when a registrant appears before an examining board he is under the jurisdiction of that board and can be directed to undergo such treatment. Conjecturing that a majority of such persons would be willing and eager to receive free treatment, Mr. Roosevelt said that in cases of recalcitrancy the registrant could be inducted into the Army, placed under Army orders and commanded to undergo treatment. The President disclosed that the Army also had presented an alternative program, which he rejected, calling for induction of all rehabilitable cases and their treatment in Army medical centers.

When costs of housing, food, clothing, Army pay and medical care in this program were considered, Mr. Roosevelt said it would involve expenditure of approximately $500,000,000. The salvage program by local physicians and dentists which he has approved will cost far less than that, he said.

The President disclosed that plans already are well advanced for the salvage program. In cases of heart and musculoskeletal diseases, as well as mental and nervous cases, persons considered by local boards as being susceptible to rehabilitation will be placed in a special selective service category. Remaining under orders of their selection boards, these men will be visited by traveling boards or "teams" of prominent specialists, who will examine them and recommend curable cases for immediate treatment at Government cost.

The Selective Service report itemized as causes for rejection:

Dental defects, 188,000 cases, 20.9 per cent.
Defective eyes, 123,000 cases, 13.7 per cent.
Cardiovascular diseases, 96,000 cases, 10.6 per cent.
Musculoskeletal defects, 61,000 cases, 6.8 per cent.
Venereal diseases, 57,000 cases, 6.3 per cent.
Mental and nervous diseases, 57,000 cases, 6.3 per cent.
Hernia, 56,000 cases, 6.2 per cent.
Defects of ears, 41,000 cases, 4.6 per cent.
Defects of feet, 36,000 cases, 4.0 per cent.
Defective lungs, including tuberculosis, 26,000 cases, 2.9 per cent.
Miscellaneous, 159,000 cases, 17.7 per cent.

The President said that in the cases of dental defects, hernias, eye trouble, and even cardiac and musculoskeletal defects, the ratio of cures is expected to be relatively high. Venereal cases are especially susceptible of salvage, he said, and venereal-infected registrants will be kept under the orders of selection boards and instructed to get themselves cured quickly and report back for service. The salvage program, Mr. Roosevelt admitted, leaves for future consideration the larger question of why half of American youths are physically and mentally defective and why 100,000 had to be rejected because of a lack of a fourth-grade education.

Colonel Leonard G. Rowntree, chief of the Selective Service Medical Division, after a conference with the President, said that the preliminary figures point to the inescapable conclusion that there is an urgent need for a national campaign for improvement of general health.—*The Journal of the American Medical Association,* October 18, 1941.

* * *

Rehabilitation of the Draftees

At his press conference on October 10 the President of the United States indicated a plan for rehabilitation of the draftees who are classified at the time of their first physical examination as being susceptible of rehabilitation at a reasonable cost in a comparatively short time. Estimates publicly announced by different agencies have indicated that the number susceptible of rehabilitation varied from 20 to 50 per cent of those rejected as unfit. As indicated in the item published under the heading of Medical Preparedness in the current issue of *The Journal,* the President apparently accepted the more scientific estimates submitted to him; he indicated that approximately 200,000 men would be susceptible of rehabilitation for military service.

No doubt the large majority of those susceptible of rehabilitation represent draftees whose difficulties are concerned with the teeth. Thus, much of the burden of rehabilitation will fall on the dental profession. Apparently representatives of the press who interviewed the President were doubtful about the possibility that draftees would volunteer for rehabilitation or that they could, under some type of legal ruling, be compelled to undergo necessary rehabilitation. The President, however, seems to have had legal opinions as to how such rehabilitation might be compelled, once the draftee came under the control of his Selective Service board. . . .—Editorial in *The Journal of the American Medical Association,* October 18, 1941.

* For editorial comment, see page 226.

Concerning Physical Defects of Selectees

In the *Press Democrat* of Santa Rosa, issue of October 24, 1941, Dr. W. C. Shipley, a member of the Sonoma County Medical Society, has an article concerning the experience of the local Board of Medical Examiners of selectees, to which he has attached his observations concerning the nature of some of the physical defects and their causes.

Because so much misunderstanding has arisen concerning the background of physical defects that interfere with a man's "military fitness" as contrasted with "utilitarian fitness," the following excerpts from Doctor Shipley's article are presented in this column:

The greatest trouble is poor teeth, insufficient natural teeth and in some cases no teeth at all.

Heart and blood vessels come next, along with high blood pressure, poor eyesight, defective hearing or diseased ears, hernias, hemorrhoids, varicose veins, bodily deformities, underweight, overweight, kidney disease, diabetes, congenital defects, disturbances of the endocrine glands—especially the thyroid and pituitary—mental subnormals neurotic, etc., all contribute a share in the unfortunate picture.

Very few have been found tubercular and less than two per cent are afflicted with syphilis and about the same number with other sex diseases.

Of the overweights a few are due to supernutrition, but the bulk are caused by glandular disturbances or imbalance.

The underweights are all the result of malnutrition; in other words, improper food and a desire to burn the candle at both ends.

Three have been found who could not read or write sufficiently to be able to make out their own papers, as they had only a few months' schooling; yet all three were born and reared in California.

Now as to the causes of these defects—bad teeth, poor postures, underweight—some skeletal defects are due to lack of proper food, malnutrition, and lack of medical, dental and parental care in infancy and childhood.

Too Much Trash

Too much trash—candy, lollypops, soft drinks, soda-fountain goos and highly refined, premasticated and predigested foods devoid of vitamins which give the whole digestive system, from the mouth all the way through the body, little or no work to do, and as a result the whole bodily functions get lazy and fall down on the job of building a perfect human being.

Some of the heart-trouble cases were born that way, some result from infections such as rheumatism, pneumonia, diphtheria, or infected tonsils.

Quite a number result from overstrain and excessive competitive athletics in school—they are forced to their utmost, to do or die for their dear old alma mater, with a desire to make stars of themselves and a great record for their school—all to the physical detriment of a growing and still plastic body.

Blames Athletics, Cigarettes

Intensive competitive athletics are a definite cause of heart trouble, flat feet, damaged bones, joints, muscles and tendons, as well as some other body organs.

Excessive use of cigarettes are also a fruitful source of heart, lung, and nervous system misfortunes. Some very few can trace their trouble to excessive use of alcohol.

We have found none suffering from overwork, for most people when they do work seldom overtax their bodies.

Late and irregular hours in the formative period of life add their share to the cause of deficiencies in later life and so the picture of physical unfitness in this great and glorious land of ours, the country with the highest standard of living in all the world, with about half its young men unfit for military service, is not one of beauty or to be proud over.

The correction of these defectives, or rather their prevention in future generations, is a gigantic task and, like the labors of Hercules, will prove to be a task greater than one man can solve, but a few suggestions might not be out of order.

Children and those in their early teens should have regular hours, go to bed early, rise early, have plenty of outdoor exercise, a properly balanced diet which requires chewing, without a flock of trashy foods, bubbly drinks, knicknacks, fancy dishes, along with proper exercise and periods of rest.

If we all followed that Biblical injunction, "Be ye temperate in all things," it would redound to our physical, mental, moral, and social well-being.

Of course, many of those now unfit are beyond complete repair; many could be restored to a fair condition of physical fitness by medical, surgical, and dental care.

Must Look to Future

Our greatest job will be the prevention of these sad conditions in the boys and girls to come in future generations.

We compel our youth to attend school and get an education. Now, a healthy body is as important or even more so to national welfare than an educated mind; so it would seem proper medical and dental care from infancy to adult life and on to its end, with proper diet and reasonable physical training, with regular physical examinations at stated intervals so that any beginning trouble may be discovered and checked before it gets the upper hand, is the basis upon which to build a mentally and physically nearly perfect population. . . .

* * *

One Physical Selectee Quiz Is New Plan

From an October 8 dispatch, dated Washington:

In an apparent effort to meet a major criticism of the draft program, selective service officials said today that by January 1, draftees will be required to undergo only one physical examination for induction into the army.

At present, draftees are examined by selective service physicians attached to their local boards and then must be reëxamined by army doctors before being accepted for service. In many cases, men have given up their jobs and sold their belongings only to fail the army's medical examination.

Under the new plan, draft officials said, the registrants would know "almost for a certainty" that if they pass the single examination by army doctors, they will be inducted into the armed forces. The new program also will relieve in part the burden on thousands of private doctors who have been conducting the examinations at local draft boards on a voluntary basis.

The new plan calls for each state to be divided into districts, with army physicians conducting examination of selectees in each. In the more congested areas, examination stations will be established on a full time basis while in sparsely settled areas, the tests will be given at stated intervals. Whenever possible, the draftees will be permitted to return to their homes on the same day they are examined so as to disrupt their private affairs as little as possible.

Army corps area commanders have been instructed by the war department to expedite the program but it probably will not be in operation throughout the country until next January 1.

* * *

We Salvage Aluminum Pots; Why Not Men?

The draft has already shown a million young Americans physically or mentally unfit to carry a gun, or lacking the most rudimentary education. This would be appalling if it were beyond correction, a handicap on defense, a mortgage on society in pursuits of peace.

The Chronicle, at the start of the draft, urged that the opportunity to raise the physical standards that obviously would be presented by draft examination results, be used as soon as it might be done without interrupting the immediate necessities. That time, Mr. Roosevelt believes, is at hand and he proposes a salvage program for this human material.

Of the million rejected, Mr. Roosevelt says reports show that about 200,000, or one in five, can be readily brought to par. Some 100,000 are without the equivalent of a fourth grade education, but are physically fit and mentally alert. Most of the remaining 700,000 can be fitted for limited service. There are some, of course, beyond reach of correction. But these are not a problem of rehabilitation, some are beyond it, others are not necessarily social liabilities if we remember that Beethoven and Edison were deaf, Milton was blind, Van Gogh minus an ear, Steinmetz a hunchback.

The method and cost of salvaging the million, and others as disclosed, are to be considered. The best method, Mr.

Roosevelt believes, is to let the individuals select their own doctors and dentists. If they have no choice, professional service may be assigned through draft authorities. The cost, Mr. Roosevelt has not attempted to estimate at this time. To induct the 200,000 and treat them under Army supervision he says has been estimated as high as $500,000,000.

If the sole purpose were to obtain the fittest material at the cheapest possible price, it might be coldly practical to say the Government should take the best and let the rest shift for themselves. But they are part of the Nation that the best are called upon to defend. From the social viewpoint there also is a practical issue. The cost may be, must be, balanced against the value of military service, full or limited, of a million young men and also their peacetime value compared with what it may be if their defects are neglected. Their condition will not be static.—Editorial, from San Francisco *Chronicle*, October 11.

* * *

On "Utilitarian Efficiency": California Youth Administration

At least 80 per cent of California youth between the ages of 17 and 25 are in "utilitarian" physical condition, it was estimated this week by Robert Wayne Burns, State National Youth Administrator, on the basis of 10,910 complete physical examinations conducted within recent months by NYA employed physicians under the direction of Lowne W. Bell, NYA State Health Supervisor, and Dr. Wilfred Halverson, NYA Health Consultant and Los Angeles County Health Officer.

"Utilitarian," Burns explained, "means that youths may safely be assigned to practically any type of work appropriate to their sex."

The estimate was formulated on the factual basis of a detailed breakdown of the 1,928 examinations given in July. Of these, 420 or 21.8 per cent, were free from any defect; 897, 46.5 per cent, had slight correctible defects of teeth, vision, etc.; 448, 23.2 per cent, had slight permanent defects, not serious in nature; 110 youths were definitely handicapped physically; 51 were temporarily unemployable and only 2 were permanently unemployable.

On the basis of the July examinations, 91.5 per cent of the youths examined were physically able to undertake practically any type of work.

Since the total of 10,910 examinations have been of youths living in the same areas and under similar conditions to the youths examined for the July breakdown, Burns pointed out that 80 per cent would be a safe, conservative estimate of the percentage of physical fitness among the youth of the State.

He stated his belief that the 10,910 examinations represent an accurate cross-section of California's youth population. . . .

Burns stated that NYA is referring youths with ailments to physicians for treatment as fast as its restricted referral facilities will permit. NYA employed physicians do not give treatment, themselves, except at resident projects but merely examine the youths and urge them to remedy health defects through treatment by local physicians.

Health conditions at NYA resident projects, of which there are twelve throughout the State, were announced as excellent. Out of a total of 36,295 youth-worker days in July, only 570 were lost from sickness—about 1.5 per cent.

* * *

500,000 Women to Be Taught Home Nursing

Project Undertaken by Red Cross as Civil Defense Measure

Nation-wide expansion of American Red Cross classes in home nursing to reach 500,000 American housewives in the next year was announced in Washington by Chairman Davis. . . .

The new goal, six times the number trained last year, will require 15,000 registered Red Cross nurse instructors, Chairman Davis reported. Last year 2,500 nurses, many volunteering their time, taught 80,000 women and girls.

The women receiving this instruction, he said, will form a vital adjunct to overtaxed medical, nursing and hospital facilities, and will be of inestimable value to the nation in the event of epidemics or national defense emergencies. . . .

For adults the course takes six weeks, covering 24 hours of class instruction, of which 70 per cent consists of practice work making use only of such equipment which the average family would be expected to own. Positive health measures are stressed, as well as subjects such as care of babies, children and the aged. Under no circumstances does the certificate presented for completion of the course entitle the receiver to serve outside her home for remuneration. Nor is the instruction intended to eliminate the need of professional medical or nursing assistance.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION†

Approved Insignia for Licensed Physicians

(COPY)

STATE OF CALIFORNIA
DEPARTMENT OF MOTOR VEHICLES
CALIFORNIA HIGHWAY PATROL

September 13, 1941.

Pursuant to Section 454.2 of the Vehicle Code, effective September 13, 1941, the insignia indicated below has been approved and may be displayed by licensed physicians. Said

insignia shall exempt licensed physicians from Section 511, Prima Facie Speed Limits, when traveling in response to emergency calls.

† Component County Societies and California Medical Association members should not give endorsements to proposed legislation unless the California Medical Association Committee on Public Policy and Legislation has so requested. On such matters, address: California Medical Association Committee on Legislation, Dwight Murray, M. D., Chairman, 450 Sutter, San Francisco. Telephone, DOuglas 0062.

The insignia must be displayed upon the rear of the vehicle and must conform to that shown below, which has been approved by the Department.

Approximate Size—Three inches wide by 3¾ inches high.

Color—Border, letters, outlines, wings: tan. Snakes: light green. Staff: chromium plate. Torch: flame red. Background: cream.

(Signed) JAMES M. CARTER,
Director, Department of Motor Vehicles.
(Signed) E. RAYMOND CATO,
Chief, California Highway Patrol.

* * *

For the convenience of members who did not read the editorial comment in the September issue of CALIFORNIA AND WESTERN MEDICINE, concerning the new traffic law relating to physicians, the following comments may be of interest:

At the Coronado meeting, Doctor Bullock of Los Angeles introduced Resolution No. 24 for proposed legislation granting traffic law exemptions to physicians when responding to emergency calls, the same being adopted (CALIFORNIA AND WESTERN MEDICINE, June, 1940, pages 271 and 294). An act drafted and introduced as Assembly Bill 690 went on to enactment, now being recorded as Chapter 573, Section 454.2 of the Vehicle Code of California. Reference to this measure is made under Item 20 of the minutes of the California Medical Association Council, appearing in this issue on page 144.

The text of the new law which, with other statutes, will become operative ninety days after the June 14 adjournment, namely, on September 3, reads as follows:

"The people of the State of California do enact as follows:

"Section 1. Section 454.2 is hereby added to the Vehicle Code, to read as follows:

"454.2. Vehicles Owned by Physicians. A physician traveling in response to an emergency call shall be exempt from the provisions of Section 511 of this code; provided, the vehicle so used by him displays an insignia approved by the Department of Motor Vehicles, indicating that such vehicle is owned by a licensed physician. The provisions of this section shall not relieve the driver of any such vehicle from the duty to drive with due regard for the safety of all persons using the highway, nor shall the provisions of this section protect any such driver from the consequences of an arbitrary exercise of the privileges declared in this section."

It is to be regretted that the statute did not provide that the special insignia, to be placed on automobiles, should be secured from the California Department of Motor Vehicles, through applications previously approved by the state examining boards of physicians. However, the beginning has been made.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

San Diego Postgraduate Conference

Under the auspices of the San Diego County Medical Society, a postgraduate conference, conducted on three successive evenings, was carried through on Tuesday, Wednesday, and Thursday, October 28, 29, and 30.

The first session was a dinner meeting at the University Club, on Seventh Avenue, held on Tuesday evening at 6:30 o'clock.

The second meeting took place in the auditorium of the Mercy Hospital, on Hillcrest Drive, on Wednesday at 7:30 p. m.

The last of the three meetings was also held in the auditorium, Mercy Hospital, on Thursday at 7:30 p. m.

The members of the following county medical societies were invited: San Diego, Imperial, Orange, Riverside, and San Bernardino.

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

Program follows:

Tuesday, 6:30 p. m., October 28

Guest Speaker: John C. Ruddock, M. D., Los Angeles.
On: Ascitis; Palpable Liver; Alcoholism; Ascitis in Women; Vague Upper Abdominal Pains; Latent Jaundice.

Wednesday, 7:30 p. m., October 29

Guest Speaker: Eric Larson, M. D., Los Angeles.
On: Duodenal Ulcer; X-Ray Diagnosis of Cancer of Stomach; Exploratory or Abdominal Adhesions with Vomiting and Distress; Esophageal Hernia.

Thursday, 7:30 p. m., October 30

Guest Speaker: William C. Boeck, M. D., Los Angeles.
On: Acute Gastritis, Such as Is Seen from Alcoholism; Hemorrhagic Gastritis; Massive Hemorrhage of the Stomach and Its Treatment; The Diagnosis and Treatment of Penetrating Gastric Ulcers.

* * *

Eighth Councilor District Postgraduate Conference

In Chico, at Hotel Oaks, on Saturday afternoon and evening, and Sunday morning and afternoon, November 1 and 2, the members of the Eighth Councilor District held a two-day Postgraduate Conference—their second—the first having been held last year at Lake Tahoe. The counties of the Eighth Councilor District include: Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo, and Yuba.

The Conference was held under the auspices of the Butte-Glenn County Medical Society. Councilor Frank A. MacDonald of Sacramento and a local committee supervised the arrangements. The dinner and luncheon reservations were in charge of Dr. J. O. Chiapella of Chico.

Program follows:

FIRST DAY: SATURDAY, NOVEMBER 1

2:00 p. m.—*Registration.*
3:00 p.m.—*Postgraduate Conference.*
Chairman, Charles Benninger, Oroville, President, Butte-Glenn County Medical Society

The Clinical Use of Sulphonamide Compounds—Maurice Tainter, Professor of Pharmacology, Stanford University School of Medicine.

Diagnosis and Treatment of Anemia—Stacy R. Mettier, Associate Professor of Medicine, University of California Medical School.

The Treatment of Compound Fractures — Carleton Mathewson, Jr., Associate Professor of Surgery, Stanford University School of Medicine.

7:00 p. m.—*Banquet.*
Toastmaster, Dan Moulton, Chico, Past President, Butte-Glenn County Medical Society.
Speaker: Honorable Charles H. Deuel, Chico, Senator, Sixth California District.
Subject: Medical Legislative Problems.

9:00 p. m.—*Entertainment:* Music, cards, refreshments, etc.

SECOND DAY: SUNDAY, NOVEMBER 2

8:00 a. m.—*Breakfast.*
9:00 a. m.—*Postgraduate Conference.*
Chairman, Joseph O. Chiapella, Chico, Secretary Butte-Glenn County Medical Society

The Treatment of Hemorrhagic Diseases—Stacy R. Mettier, Associate Professor of Medicine, University of California Medical School.

The Recognition and Treatment of Acute Bowel Obstruction—Carleton Mathewson, Jr., Associate Professor of Surgery, Stanford University School of Medicine.

The Medicinal Treatment of Gastro-Intestinal Conditions—Maurice Tainter, Professor of Pharmacology, Stanford University School of Medicine.

1:00 p. m.—*Luncheon—Organization Meeting.*
Chairman, Frank A. MacDonald, Sacramento, Councilor, Eighth District

Remarks—Henry S. Rogers, President, California Medical Association.

Medical Practice Act—William R. Molony, President-Elect, California Medical Association.

Organization Activities—George H. Kress, Secretary-Editor, California Medical Association.

Basic Science Initiative—John Hunton, Executive Secretary, California Medical Association.

Medical Legislation—Ben H. Read, Executive Secretary, Public Health League of California.

Southern California Chapter: American College of Surgeons

Three hundred members of the Southern California Chapter of the American College of Surgeons continued their clinical observations in Los Angeles hospitals recently.

From ward to ward went the visiting scalpelmen, eyeing condition charts, hearing surgeons explain cases, offering their talent freely in many an impromptu bedside consultation.

At California Hospital they discussed deadly carcinoma, that strange malignant proliferation of wild cells that chokes the channels of life.

At Cedars of Lebanon they heard much of patching the body's inner tubes, as prominent local surgeons explained their technique of dealing with ailments of the colon.

At Hollywood Hospital obstetrical pathology was programmed, and at Orthopedic Hospital a lot was said about the diseases of children.

Afflictions of the eye, ear, nose, and throat were investigated at the Los Angeles County Hospital, and at Good Samaritan Hospital various difficult surgeries were studied.

At the Los Angeles County Medical Association building the surgeons listened to lectures on medication—what to do if surgery fails, or how to aid repair jobs with healing drugs.

These include vitamins, hormones and various minerals, including iodin, which are coming to be used as adjuncts to surgery.

Uses of the newer sulfonamide drugs in their relation to the control of surgical conditions is being clarified, states a note on the program of the convention.

* * *

Dr. Donald G. Tollefson of Los Angeles was elected president of the Southern California Chapter of the American College of Surgeons at an annual banquet and election, which climaxed a two-day session of the organization in the Los Angeles County Medical Association building.

Dr. Charles M. Fox of San Diego was elected vice-president of the group, and Dr. Harold Lincoln Thompson of Los Angeles was installed as secretary-treasurer.

Executive committeemen elected were: Doctors Henry V. Findlay of Santa Barbara, Thomas Card of Riverside, Jacob H. McCracken of San Pedro, and Carl Rusche and Ray Irvine of Los Angeles.

* * *

Doctor Winslow Teaching at California

Dr. C. E. A. Winslow, Professor of Public Health at Yale University, has been appointed Rosenberg Lecturer in Public Social Services at the University of California for the fall semester of 1941.

* * *

Inactive Duty Training: Medical Reserve Officers' Conferences

The attention of Medical Reserve Officers is called to a communication in the Letters department of this issue regarding monthly conferences to be held at the Presidio of San Francisco (see page 276).

* * *

Salmon Memorial Lectures: In San Francisco

Final dates for the Salmon Memorial Lectures which Dr. Robert D. Gillespie, psychiatric specialist of the British Royal Air Force, will deliver in key cities of this country and Canada, have been announced by Dr. C. Charles Burlingame, chairman of the Salmon Committee on Psychiatry and Mental Hygiene. The schedule of lecture dates was completed after an exchange of cables between the Salmon Committee and Sir Harold Whittingham, Director General of the Medical Services of the Air Ministry in London.

Doctor Gillespie has received special leave of absence from the RAF from the British Government for the express purpose of delivering the Salmon Lectures in this country and Canada. He will fly here to make a first-hand report to members of the American medical profession and officers of the United States Army and Navy Morale Division on the psychological effects of "blitz" warfare on civilian and armed forces.

The tentative date for Doctor Gillespie's appearance in San Francisco is Thursday, November 27, under the sponsorship of Leland Stanford University, University of California, and the San Francisco Psychiatric Society.

Doctor Gillespie's observations, made under actual war conditions, are expected to be of inestimable value to American psychiatrists in formulating plans for maintaining civilian morale in wartime.

A general invitation to members of the medical profession and their friends to attend the lecture has been issued by the Salmon Committee. Doctor Gillespie will be the ninth lecturer who has been selected from top-ranking psychiatrists and neurologists throughout the world for making the greatest contribution to their field during the preceding year. Selection for the Salmon Lectures has been likened to selection in the Pulitzer prize in letters.

* * *

California Mental Hygiene Society

Personality Problems to Be Discussed

Personality problems and their treatment is the subject of five case presentations to be given by the Northern California Mental Hygiene Society on successive Wednesday evenings during November and December, beginning on November 12.

The *chronic alcoholic* will be considered at the November 12 session. Dr. Percy Poliak, Director of the Clinic for Alcoholics at the San Francisco Hospital, will present the case study. A member of the San Francisco Police Department and of the Department of Social Welfare will discuss the problem from their point of view. The psychological mechanisms involved in the behavior of the alcoholic and methods of treatment, including those of the alcoholics anonymous, will be discussed.

The *adult psychiatric problem* will be presented on November 19 by Dr. Sophie Merviss, psychiatrist, from the Mount Zion Psychiatric Clinic. A social worker and psychiatric social worker will demonstrate how they coöperate with the psychiatrist in working out the problem.

Psychiatric therapy in family relations will be discussed on November 26. Irma Blethen of the Family Service Agency will present a case. Dr. George Johnson and Pearl Axelrod will show how the psychiatrist and psychiatric social worker work out a program of therapy with a community agency.

The problem child and what can be done for him in a child-guidance clinic will be the basis for discussion on December 3. A social worker, psychologist, and pediatrician will demonstrate what each specialist contributes in solving this problem. Dr. Hale Shirley, Director of the Child-Guidance Clinic at Stanford University Hospital, will give the case presentation. Dr. Mary Layman, professor of pediatrics, and Dr. Joseph Solomon, psychiatrist, will also appear on this program.

The relationship of *vocational adjustment* to the solution of other personality problems is the subject of the conference on December 10. Methods of diagnosis and job placement will be discussed by Barbara Mayer, Supervisor of the Counseling Service of the State Department of Employment. Mary Rapp, psychologist, will assist with the case presentation. Dr. Edwin Ghiselli of the University of California and Max Levin, psychologist from Homewood Terrace, will discuss the work of this clinic in the community.

The case discussions will be held at 8 p. m. at the Sorosis Club auditorium, 536 Sutter Street. For further information, address Northern California Mental Hygiene Society, 45 Second Street, Room 409, San Francisco.

* * *

Southern California Medical Association—105th Semi-Annual Session

The Southern California Medical Association will hold its 105th semi-annual meeting on Friday and Saturday, November 14 and 15, 1941, at the Huntington Hotel, Pasadena. A program has been arranged which includes subjects of sufficient general interest to be of value to the specialist and general practitioner alike.

The Association is fortunate in having secured two outstanding guest speakers.

Dr. Karl Meyer, Director of the Hooper Foundation for Medical Research at the University of California, will address the Association and will act as moderator for a symposium on "Chronic Fevers."

Dr. Charles E. Smith, Professor of Public Health at Stanford University School of Medicine, will also address the Association. Doctor Smith is a noted authority on coccidioidomycosis and on many problems relating to public health.

It is sincerely hoped that whether or not you are a member of the Association, you will avail yourself of the advantages of the forthcoming meeting.

For further information, address Edward W. Boland, M. D., 2202 West Third Street, Los Angeles.

COMMITTEE ON INDUSTRIAL PRACTICE

Rule 19 of the Industrial Accident Commission—the rule requiring the furnishing of all medical reports in litigated compensation cases—was hardly dry on the books before one large insurance company sent form letters to all physicians handling its medical work, asking that in all industrial accident cases the physician furnish the insurance company with five copies of all medical reports.

While the adoption of the Commission's new rule caused no sensation among the doctors, the insurance company's form letter drew an immediate response. Discussion brought out the fact that most doctors' offices are not mechanically equipped to handle multiple copy typing, that there is a large expense involved in extra time, stationery, supplies and care, and that there is nothing in Rule 19 to require that copies of medical reports be carbons of the doctor's original report. There was considerable grumbling about the insurance company's trying to push off on the doctors the extra clerical work involved in Rule 19.

At the request of several members, the California Medical Association central office talked this matter over informally with the insurance company which had asked for the extra copies of reports. It was pointed out that more than 80 per cent of all industrial accident cases require only treatment and never get to the stage of litigation. Of the 20 per cent on which compensation is allowed after the legal waiting period, not more than half (or about 10 per cent of all industrial accident cases) go into litigation, which would require the filing of additional copies of medical reports.

On the strength of these representations, the insurance company has agreed to make its own copies of medical reports where they are needed. Any doctor who feels he should not carry the burden of extra clerical work demanded by the insurance company's original request is at liberty to ignore the request.

In case the Industrial Accident Commission should rule at a later date that all copies of medical reports must bear the doctor's own signature, the California Medical Association can take appropriate action. With all industrial compensation work being done at fees that are admittedly low, there appears no adequate reason for additional office burdens to be placed on the doctors.

* * *

Council on Industrial Health, American Medical Association

State Committee Activity

Recent meetings which have been held in Michigan, Indiana, and Kentucky, suggest that a restatement of the original program of activities designed for committees on industrial health in state and county medical societies would be helpful. The following is a brief summary of the plan presented in Bulletin No. 3, which recommended three main types of activity:

1. *Investigation.*

(*a*) The medical needs of industry can only be determined through familiarity with the character of industrial processes, hazards and health programs existing in the community.

(*b*) A census of the physicians specializing in, or giving attention to, industrial practice with their industrial connections and the scope of the service they provide should be compiled.

(*c*) The type of service that the private practitioner can render to the small plant through a health maintenance program needs investigation.

(*d*) Physical examination is the most likely basis for early common interest to industry and the physician alike and needs careful study and control.

2. *Correlation.*

(*a*) The activities of local organizations which are or should be interested in industrial health problems needs coördination to avoid duplication of effort. The list should include: Health departments, industrial hygienists, industrial nurses, safety councils, manufacturers' associations, labor organizations, casualty insurance adjusters, and bar associations.

3. *Education.*

(*a*) Education of the medical profession by all available means for instruction about the services that can be rendered to industry is a direct responsibility of the state and county committees.

(*b*) The educational program should also include proper instruction of industrial nurses, plant management, employees, and the general public about the benefits of industrial health services.

(*c*) The responsibility for developing a program of industrial health to meet present-day needs must lie primarily with the committees organized for that purpose in the state medical societies. The extension of a policy of guidance and inspiration to county society committees should yield much wider and more intensive activity. It is in the county society where the acute problems of an industrial-medical nature are encountered and where they can be most directly dealt with. More intimate contacts made by a larger number of the medical profession, will mean far greater influence upon standards in industrial practice.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (25)

Imperial County (1)

S. R. Edwards, *El Centro*

Monterey County (1)

Sebastian A. Carnazzo, *Monterey*

Riverside County (2)

Richard N. Boylan, *Riverside*
Charles J. Miller, *Riverside*

San Diego County (1)

J. B. McConnell, *San Diego*

San Francisco County (12)

Jack Kenneth Afflerbaugh, *San Francisco*
August A. Antipa, *San Francisco*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

Isaac Arnowitz, *San Francisco*
Charles H. Cutler, *San Francisco*
Edward E. Fong, *San Francisco*
Maurice L. Kamins, *San Francisco*
Frances M. Keddie, *San Francisco*
Elise M. Rose, *San Francisco*
Elliot G. Schneider, *San Francisco*
Thomas L. Schulte, *San Francisco*
Richard Clifford Smith, *San Francisco*
Forrest M. Willett, *San Francisco*

Santa Cruz County (2)

A. David Garibotti, *Santa Cruz*
Frances M. McKay, *Santa Cruz*

Tulare County (5)

George B. Armanini, *Sunnyvale*
E. K. Blasdel, *Tulare*
W. D. Clinite, *Tulare*
A. W. Dagoberg, *Porterville*
Cyril H. Johnson, *Tulare*

Ventura County (1)

John N. Stewart, *Santa Maria*

Resigned (1)

John Aloysius Fershtand, from San Francisco County.

In Memoriam

Baron, Peter Paul. Died at Alameda, September 17, 1941, age 49. Graduate of College of Physicians and Surgeons, Los Angeles, 1918. Licensed in California in 1921. Doctor Baron was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Bogle, Samuel Saffell. Died at San Francisco, September 27, 1941, age 74. Graduate of University of Tennessee College of Medicine, Memphis, 1891. Licensed in California in 1893. Doctor Bogle was a member of the Sonoma County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✝

Kell, Fred B. Died at San Bernardino, April 22, 1941, age 53. Graduate of St. Louis University School of Medicine, Missouri, 1913. Licensed in California in 1914. Doctor Kell was a member of the San Bernardino County Medical Society, the California Medical Association, and the American Medical Association.

✝

Martin, Albert Thomas. Died at Los Angeles, September 16, 1941, age 43. Graduate of Johann Wolfgang Goethe Universität, Medizinische Fakultät, Frankfurt-am-Main, Prussia, 1922. Licensed in California in 1924. Doctor Martin was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Morrow, Howard. Died at San Francisco, October 22, 1941, age 66. Graduate of University of California Medical School, San Francisco, 1896. Licensed in California in 1896. Doctor Morrow was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

Reynolds, Frank Chester. Died at Chico, September 20, 1941, age 32. Graduate of University of Southern California School of Medicine, Los Angeles, 1935. Licensed in California in 1935. Doctor Reynolds was a member of the Butte-Glenn County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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OBITUARY

Howard Morrow
1874–1941

Howard Morrow, nationally noted physician and a former vice-president of the American Medical Association, died at his home in San Francisco on Wednesday afternoon, October 22, 1941.

His death from a heart attack came as a shock to the medical profession and to thousands who had known him during his nearly half a century of practice.

A native San Franciscan, born November 12, 1874, Doctor Morrow was graduated from the University of California Medical School in 1896, and later became clinical professor of dermatology in his alma mater, and remained as head of the dermatology department up to the time of his death. He was president of the American Dermatological Association in 1918, and was a member of the Dermatological Associations of Great Britain and of Vienna.

He was elected vice-president of the American Medical Association in 1938 during its national convention in San Francisco.

In the past decade, he had been president of the California Medical Association (1937), and president of the State Board of Public Health (1933-1940).

For many years, Doctor Morrow was a consulting physician for the U. S. Marine Hospital and the United States Public Health Service.

As head of the California State Board of Public Health, he was instrumental in launching many important investigations concerning the causes and prevention of communicable diseases.

Doctor Morrow was a member of Alpha Kappa Kappa, Alpha Omega Alpha, the Family Club, the Olympic Club, and the Menlo Country Club.

He leaves a widow, Mrs. Mary Weldon Morrow, a daughter, Mrs. Maryle Doerflinger; three sons, Weldon, Robert and Dr. Grant Morrow, and a brother, William G. Morrow of San Francisco.

In the medical profession and among his friends and fellow citizens he was much beloved, and his passing leaves a distinct void. His will be a difficult place to fill.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. HARRY O. HUND.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM.....Asst. Chairman on Publicity

Meeting of Board of Directors

On Friday, September 19, Mrs. Harry O. Hund, State President, met with her Board of Directors in an all-day session at the Women's City Club in San Francisco. The following officers and directors were present:

Officers: Mrs. Harry O. Hund of San Rafael, president; Mrs. F. G. Lindemulder of San Diego, president-elect and chairman of finance; Mrs. R. Stanley Kneeshaw of San Jose, first vice-president and chairman of membership and organization; Mrs. Ralph B. Eusden of Long Beach, second vice-president and chairman of program and health education; Mrs. R. K. Cutter of Berkeley, recording secretary; and Mrs. Frank A. Lowe of San Francisco, corresponding secretary.

Councilors-at-Large: Mrs. Rene Van de Carr of Piedmont, chairman of publicity.

District Councilors: Mrs. G. W. Coon of Riverside, Mrs. Franklin Farman of Los Angeles, Mrs. Allan J. Pederson of Santa Cruz, Mrs. M. R. Gordon of San Francisco, Mrs. Kaho Daily of Richmond, Mrs. Charles C. Landis of Chico, and Mrs. H. R. Madeley of Vallejo.

Chairman of Committees: Mrs. Hobart Rogers of Oakland, parliamentarian; Mrs. Lincoln Brown of San Francisco.

Mrs. Edmund J. Morrissey of San Francisco, treasurer; Mrs. Eric Colby of Bakersfield, chairman of public relations; Mrs. R. Emerson Bond of San Diego, chairman of public health activities; Mrs. Franklyn D. Hankins of Riverside, chairman of *Hygeia*; Mrs. J. C. Sharp of Salinas, convention chairman; Mrs. Arthur T. Newcomb of Pasadena, historian. Mrs. Louis A. Packard and Mrs. J. C. McClure, district councilors, were absent.

The following county presidents attended: Mrs. C. C. Landis, Butte; Mrs. J. R. Walker, Fresno; Mrs. H. N. Hensler, Marin; Mrs. Martin McAulay, Monterey; Mrs. Gustave Wilson, Sacramento; Mrs. E. R. Christopherson, San Diego; Mrs. Norman Sullivan, Santa Cruz; Mrs. Eugene Kilgore, San Francisco; Mrs. O. A. Sharpe, San Mateo; and Mrs. F. B. Jones, Solano.

Mrs. Hund graciously welcomed members of the Board and the County presidents, and then presented her splendid program for the year 1941-1942. Reports of the committee chairmen showed their work to be well planned for the coming year. All old business was finished promptly, and much new business was discussed.

Mrs. Hund introduced Mr. Ben Read, Executive Secretary to the California Public Health League, who explained the Basic Science Law, which is now in effect in fifteen states and the District of Columbia; California being the only Pacific Coast State which does not have such a law requiring training in the basic sciences for all who practice the art of healing (Christian Science exempted). Mr. Read said that the Auxiliary can help in securing the 30,000 signatures for the petitions being circulated, the number of signatures required to put this initiative on the ballot.

At 12:30 the San Francisco Auxiliary honored Mrs. Hund and her Board at a delightful luncheon in the City Club. Mrs. Eugene Kilgore, president of the San Francisco group, presided. Entertainment included a visit to the National Defenders' Club, and an automobile tour to places of interest in the city.

* * *

News Items

The Alameda County Auxiliary has planned its annual benefit party. It will be a bridge luncheon and Fashion Show, to be held at the Athens Athletic Club in Oakland on the regular meeting day. Mrs. George E. Kleeman is general chairman, and the models have been chosen from the membership.

The Fashion Show has been patterned on a musical theme, "A Pretty Girl Is Like a Melody," played and arranged by the Mesdames Chelsea Eaton, Milton H. Shutes, and G. Kenneth Hargrove. Proceeds from this event are to go to the Medical Benevolent Fund.

* * *

The Contra Costa Auxiliary is having a luncheon for its members in October, and has also sent invitations to Auxiliary members in neighboring counties.

The luncheon will be given at Tisbury Farm, on Walnut Creek, and will be followed by a talk on *The Third Component* by Dr. Frederic M. Loomis of Alameda County.

* * *

Humboldt County Auxiliary opened its first meeting of the year with a seven o'clock dinner at the Humboldt Golf and Country Club.

Mrs. Harry O. Hund of San Rafael, President of the State Auxiliary, was the guest speaker of the evening. A woman of unusual and charming personality, Mrs. Hund gave an interesting and instructive talk on national defense, and the duties of a doctor's wife and family toward his profession. She also gave a brief summary on the new Auxiliaries that are being organized throughout the state. Her unique suggestions as to how funds for the various projects could be raised were received with enthusiasm by the members.

* * *

Kern County Auxiliary started its fall activities with an evening meeting held at the home of Dr. and Mrs. Seymour Strongin. After disposition of the regular business, a reading of *White Cliffs of Dover* was enjoyed by the members.

* * *

The Los Angeles County Auxiliary entertained with a membership tea for new members, and all eligible members, in the beautiful home and gardens of its president, Mrs. William C. Boeck, in Beverly Hills, on September 28.

* * *

Members of the Marin County Auxiliary had their first fall meeting at Deer Park Villa in Fairfax. The most important business transacted was the decision to give $15 immediately to the State Benevolent Fund.

The members adjourned to a later date, to join their husbands at a dinner and hear talks by Mr. Ben Read and Mr. John Hunton on legislative matters and the Basic Science Law.

* * *

Members of the Merced County Auxiliary also had a meeting to honor the State president, Mrs. Harry O. Hund, at the Tioga Hotel. Mrs. Hund stressed social betterment and various ways the local group might extend its activities with the advice of the State Medical Association.

* * *

San Diego County Auxiliary held its first meeting in the Don Room of the El Cortez Hotel with a business session and luncheon. Many new and prospective members were present, and, as special guests, the wives of Army and Navy doctors were included.

Bridge and bingo were enjoyed following the luncheon, and a teller told fortunes throughout the afternoon.

* * *

The San Francisco Auxiliary held its first meeting with business and entertainment programs. Dr. Harold Fletcher, President of the San Francisco County Medical Association, addressed the members and asked all to

† Reports of county chairmen of publicity should reach Mrs. Rossner Graham, Assistant Chairman of Publicity, 6101 Acacia, Oakland, by the tenth of the month previous to publication. Address of the Chairman of Publicity: Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front of advertising section.

participate actively in all civic affairs that touch upon medicine.

Judge Theresa Meikle of the Municipal Court, as guest speaker, discussed the newly organized "Big Sister Plan," a help for girls needing advice and guidance.

The foremost activity of the autumn will be the sponsoring of a day at the San Francisco House of Hospitality in the Civic Center from 10 a. m. until 11 p. m. on Wednesday, November 5. (This is the contribution of San Francisco to men in the Government service.) Sandwiches, cakes and coffee are to be served during the day and evening, and girls, chaperoned by doctors' wives, have been invited for dancing.

Proceeds from a spring bridge party were sent to the California and Stanford Universities as a loan fund for senior medical students.

* * *

What promises to be a busy season has been inaugurated by the Santa Barbara Auxiliary. At the business meeting there was discussion of organizing a defense group within the Auxiliary to work under the Red Cross, probably to roll bandages.

Members also discussed the needs of the Girl Scout Troop which was sponsored by the Auxiliary, and plans were made to help them with a benefit tea later in the fall.

Each year the Auxiliary awards a prize of $10 to a nurse graduating from Knapp College at Cottage Hospital, who, in the opinion of the Staff, has the best bedside manner.

The meeting was followed by a tea, honoring the Army wives from Hoff General Hospital.

* * *

Santa Clara Auxiliary members as a whole are enthusiastically centered in their Community Chest Drive, and members have also volunteered to carry out the sewing and knitting program set out by the Red Cross and the British War Relief program. The first fall meeting was held in the home of the president, Mrs. George Gray, and was followed by a reading of a play by Mr. Lawrence Mendenhall of the State Teachers' College.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

September, 1939	1,220
March, 1940	9,322
September, 1940	17,398
March, 1941	24,107
September 30, 1941	30,215

Report to Professional Members: Announcement of Changes in Plan

Your Board of Trustees submits herewith a report of developments to professional members of California Physicians' Service.

California Physicians' Service has just completed its second year of operation. During the last year we have had an average membership of over 20,000 and have now reached 30,000. Our experience during the first year could not be considered as a valid basis for conclusions that the Service was either good or bad. In the second year of operation, however, our mechanics and techniques have been crystallized into fairly uniform procedures and methods and we may accept the findings of this second year with considerable confidence.

†Address: California Physicians' Service, 333 Pine Street, San Francisco. Telephone EXbrook, 3211. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

PIONEERING WITHOUT PRECEDENT

One of our most serious handicaps has been the lack of a similar operation that we might adopt as a pattern. No other organization has attempted this job on as broad a basis as California Physicians' Service. We could not pattern ourselves after existing private plans because it was not our intent to run a commercial enterprise but rather to develop a health service plan to meet the needs of the public and of the profession. We have been compelled to do a great deal of pioneering work in the past two years, but we have now reached a point where we feel quite confident of our course in the future.

OUR OBJECTIVES

During these past two years we have been trying to do two things: First, to determine the possibility, the cost and the mechanics of administration of an unlimited free choice medical service plan, and, second, to run a business-like operation which would pay the doctor a reasonable fee for his service. We have accomplished the first objective, but only at some sacrifice of the second. We must now mould our service and procedures so as to secure and maintain both of the original objectives.

FULL COVERAGE CONTRACTS

Almost all of the members comprising our present 30,000 have their membership under the full coverage contract which provides them free access to the doctor of their choice for any illness or injury, large or small. Under this contract California Physicians' Service sets no maximum limit on the quantity or quality of care that the doctor may wish to extend, except the limit of one year's treatment in any single illness or injury. This contract was offered to the public as an example of what the medical profession felt that a health service plan should be. It was necessary to determine the change in the habits of people and in their attitudes toward the use of medical service when they had unlimited access thereto. It must be obvious that we could not set up any arbitrary controls against the natural expression of these attitudes and habits if we expected to find the truth. We have found that the change has been radical and that the incidence of use of service has reached a height beyond our wildest predictions.

Nevertheless, it is well that we know these things. In fact, it is necessary. *If we are to arm the medical profession with "expert testimony" to prove the fallacy of government proposals for unlimited health insurance, we must secure this information from a plan equally as broad and as unlimited as those which are being proposed by government. Furthermore, this information must be current and secured from a live and going organization of considerable size if it is to be given any weight.*

Our membership of 30,000 is scattered throughout the state, with representation in every county. This is sufficient to give us an honest sample of experience with California medicine on a free and open access basis. It should be reëmphasized that any conclusions drawn from our experience are only valuable if our organization is a going one. Great capital would be made out of any attempt on our part to eliminate this program.

NECESSITY OF PROVIDING MORE EQUITABLE PROFESSIONAL FEE

Practical thinking suggests that if we are to continue the full coverage plan we must also devise new plans which will produce a more equitable fee for the professional services performed and which, combined with the full coverage plan, will not require a heavy contribution from the profession. This contribution will be relatively small in 1940 and 1941. Our present information permits us to modify our full coverage contract to secure a more equitable balance in the unit value without destroying our original concept of what this service should be.

We believe that the administrative phase of the plan is now well in hand. Our actual administrative expenses are well below the original maximum set for this purpose, and with increasing volume we can expect still further better-

ment. Even though we have pioneered in a business which had no precedent, we have been able to reduce our requirements of paper work and reports from doctors to a bare minimum. We must continue to study closely our experience with our present groups not only actuarially, but with respect to its effect upon the medical profession throughout the state. We have already recognized the wide differences in the practice of medicine in rural, urban, and metropolitan districts. The ultimate plan must give serious consideration to these factors as well as to actuarial results.

GROWTH OF CLOSED PANEL SYSTEMS

We must also study the activities of the "closed panel systems" in order that we may have an answer to the intrusions of these methods into the field of private practice. These "closed panel systems" *employ physicians on salary* to render medical care which has been *sold to the public* on a prepaid *contract* basis. These activities are gaining footholds in California at a far greater speed than is generally realized. Many thousands of *potential patients* have already been *taken away from private practice* by these "closed panel systems" which do not recognize any income limits. Their presence is very definitely felt in all parts of the state where California Physicians' Service representatives discuss health services with groups.

FACTS ESTABLISHED

In our study of the full coverage contract and our experience thereunder, we find certain facts:

1. Our incidence of illness averages better than 17 per cent, that is, almost one-fifth of our total membership is under treatment each month. This is much higher than the predictions based upon any surveys or other static forms of measurement.

2. The extent of service rendered to these patients is such that, on the average, medical service costs are equal to one unit of service per dues-paying member per month. An extremely large part of the services required by beneficiary members is for minor ambulatory illnesses and for chronic conditions.

3. Of the cases under treatment in a single month, nearly 40 per cent are continued from the previous month.

It is a very reasonable assumption that the high frequency of the use of the service, the high proportion of minor illnesses, and the dragging on of these cases is the result largely of a complete lack of responsibility on the part of the beneficiary. He need not count cost in any fashion, but merely has to present himself to the doctor and ask for whatever may be available.

4. Fifty-six per cent of our membership is composed of women who require almost 75 per cent of the care extended.

5. Too high a percentage of all membership has been secured in the white collar classes and we have not been able to secure a sufficient percentage in the industrial groups.

These last two items confirm the necessity for our expansion into new fields in order to secure a proper balance of low-income members in our Service.

6. There does not seem to be any evidence of "chiseling" on the part of professional members to any significant degree. There is no excess of services in any particular district in terms of number of patients treated nor in terms of quality of service rendered per patient.

POSSIBLE SOLUTIONS

With these facts in our possession we can plan for betterment. We have three possible solutions: First, raising dues; second, inserting some elements of cost sharing; third, a low-cost limited plan.

Item one does not propose a very practical solution by itself. Raising dues would no doubt eliminate a considerable number of our present members, and such elimination would be largely among the low income members and not among the higher income members, who have less need for the protection of the Service. However, we may do something to raise the unit value without unfairly affecting the membership as a whole. As noted above, women require 20 per cent more medical care, in proportion to their number, than the men. It seems reasonable, then, there should be an adjustment of rates for women to correct this situation.

Item two may be the source of considerable betterment. We propose that some responsibility shall be put upon the member so that he may feel a share of the burden in direct proportion to his use of the Service.

Item three is the most important with respect to policy and with respect to actuarial results. The high rate of dues necessary for the full coverage resulted in automatic selection of the "white collar" groups, who were the first to recognize the benefits to be secured through this service. Therefore, in order to correct this, we must now offer a low price plan that will attract the low income and industrial worker.

One of the most important factors we need to balance out the whole is volume, and volume can be secured with safety under limited plans which include only predictable and insurable factors. In this expansion we shall have the benefit of the experience of Eastern and Middle Western medical service associations. These organizations have found their experience entirely satisfactory with this type of contract. They have been able to secure very ready acceptance from the low income industrial groups of these limited service plans. If we can acquire volume under these contracts, it will put us definitely and safely into the low-income field. These industrial groups have not been educated to pay for a complete medical service, but in the experience of other medical service associations, once they have had the limited plan for a reasonable period of time, they manifest interest in the broader plans.

Therefore, we intend to put forth all of our effort on the acquiring of groups in the industrial field under this type of contract, limiting our acquisition activities in the full coverage plan to the two-visit deductible contract only.

CHANGES MADE BY TRUSTEES

The following changes in policy were made at the meeting of the Board of Trustees on September 20, 1941:

1. A raise in the dues for women in all new groups effective October 1, 1941, and raises in dues for women in existing groups according to our experience and as the contracts expire.

2. A moratorium upon the sale of full-coverage contracts, limiting the sale of this service to the two-visit deductible contracts only (wherein the member pays the cost of the first two visits).

3. Authorization to the secretary to cancel or modify contracts with existing groups where experience indicates abuse of the service.

4. Authorization to the Executive Committee to develop means for the inclusion of dependents of the wage-earner under the limited surgical plan.

5. Direction to the Acquisition Committee to place all of its emphasis upon the limited surgical contract in future acquisition.

The question, naturally, arises as to the over-all effect of these changes. Your Board of Trustees feels that the modification of our full-coverage contract and this expansion into new fields will result in the following:

1. We will modify our full-coverage plan and we will eliminate unsatisfactory groups.

2. We will reach a new section of the population in the low-income industrial groups.

3. We will balance the ideal full coverage with the businesslike limited coverage.

4. We will extend our service to the industrial worker and his family, whose need for protection is much greater. We assure you that your Board of Trustees is diligent and active in attempting to secure for the doctor a more reasonable return for his services, and to find for the medical profession at large the truth about medical service plans, whether they be voluntary or compulsory.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.†

California Medical Association, Hotel Del Monte, Del Monte, California, May 4–7, 1942.

American Medical Association, Atlantic City, June 8–12, 1942.

American Medical Association Meeting of State Medical Association Secretaries and Editors, 535 North Dearborn Street, Chicago, Friday and Saturday, November 21 and 22, 1941.

Forum on Allergy: Fourth Annual Conference, Detroit, Michigan, January 10 and 11, 1942.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts.*

Los Angeles County Medical Association.

The following is the Los Angeles County Medical Association's radio broadcast schedule for the month of November, 1941:

Saturday, November 1—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, November 1—KFI, 10 a. m., The Road of Health.
Saturday, November 8—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, November 8—KFI, 10 a. m., The Road of Health.
Saturday, November 15—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, November 15—KFI, 10 a. m., The Road of Health.
Saturday, November 22—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, November 22—KFI, 10 a. m., The Road of Health.
Saturday, November 29—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, November 29—KFI, 10 a. m., The Road of Health.

† In the front advertising section of *The Journal of the American Medical Association,* various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Children's Bureau Needs Maternal and Child Health Specialists.—Employment registers are to be established by the Civil Service Commission to fill maternal and child health specialist positions in the Children's Bureau of the Department of Labor. Vacancies in similar positions in state agencies coöperating with the Children's Bureau may also be filled from these registers at the request of the states concerned. The examination announcement just issued by the Civil Service Commission to recruit persons for these positions, which pay from $3,200 a year to $5,600 a year, allows the filing of applications until November 15, 1941.

There are three options in which persons may qualify—pediatrics, obstetrics, and orthopedics. For each of these options employment lists will be established for administrative, research, and clinical positions. . . .

Persons who wish to apply for this examination are advised that further information and application forms may be obtained from the Commission's representative at any first- or second-class post office or from the central office in Washington, D. C.

Cyclotron Valuable to Medicine.—The cyclotron is a new hope in medicine's search for the causes and treatment of diseases, according to Dr. John H. Lawrence, in charge of medical applications of the University of California atom-smasher.

Doctor Lawrence delivered the Caldwell Lecture at the annual meeting of the American Roentgen Ray Society.

Doctor Lawrence pointed out that valuable contributions to biology have been made, using the artificial radio-active elements produced in the cyclotron, but that "the surface has only been scratched."

Already, he pointed out, one of these elements, phosphorus, has been used to control polycythemia, a rare and fatal disease characterized by an overproduction of the red blood cells.

Radio-active phosphorus has also proved helpful in treating leukemia, a more common fatal disease characterized by overproduction of the white blood cells.

More than a score of the two hundred artificial radio-active elements produced in the cyclotron have proved useful in fundamental biological research, Doctor Lawrence said. Because they decay and emit rays, these elements can be traced in the body and in plants.

He said that the radio-active elements are being built into chemical compounds and dyes commonly found in the body and their distribution traced.

The Caldwell lecturer is chosen for outstanding contributions to roentgenology, the science of the treatment of disease with radiation. Doctor Lawrence is the twenty-second lecturer. Among previous lecturers have been Dr. Robert A. Millikan of the California Institute of Technology and Dr. Walter B. Cannon of Harvard University.

Erratum.—On page 210 of the October issue, the reference to reprints was in error. These were obtainable from the Los Angeles County Medical Association, although printed by the American Medical Association. The American Medical Association Order Department will send a price list of publications, on application.

Unregistered Births.—A recent birth registration test, conducted by the United States Bureau of the Census, revealed the startling information that there were twenty-eight unregistered births within the jurisdiction of the Los Angeles County Health Department during the four months period under study. Of this number, fifteen were hospital births. Physicians in attendance upon births are urged by the Los Angeles County Health Department Division of Vital Statistics to make certain that birth certificates are properly filed.

Doctor Kellogg Retires.—Dr. Wilfred Harvey Kellogg, the first man to make a bacteriological diagnosis of plague in the United States, retired on September 3.

Born in Kansas, Doctor Kellogg received his medical degree from the University of California in 1896. Shortly thereafter he entered the laboratory of the San Francisco Health Department. It was while there that he made his famous plague diagnosis.

Since that time, with the exception of two years spent with the United States Public Health Service, Doctor Kellogg has been associated in various capacities with the San Francisco Health Department, the California State Board of Health, the Stanford University School of Medicine, and the University of California Medical School.

From 1929 until his retirement he was chief of the Division of Laboratories of the California State Board of Health.

Sulfonamides—Clinical Aids in Recognition of Toxic Effects.—Following item is from the weekly report of the Department of Health of the City of Los Angeles:

In the intensive use of the sulfonamide drugs the resultant publicity following their investigation has sometimes overemphasized their possible toxic manifestation. Though such an attitude is necessary and justified, growing experience with these drugs makes it possible for the average physician to use them freely and without too much worry about their possible toxic effects.

Toxic reactions are frequent, but those which are dangerous are relatively uncommon.

Perrin Long suggests laboratory control whenever possibut, but also notes that practically all the toxic reactions associated with the administration of these drugs can be detected by the physician with *careful clinical control.*

Patients should be seen often and inquiry made for the symptoms of headache, body aching or malaise. In addition, observe the sclerae for jaundice and the conjunctivae for injection or paleness. Jaundiced sclerae, pale conjunctivae may connote impending *hemolytic anemia.* Jaundice without pale conjunctivae probably results from liver damage. Injected conjunctivae and sclerae, together with smarting and burning of the eyes, occurs as a toxic manifestation of sulfathiazole therapy. The oral mucous membrane should be examined and patient questioned for symptoms of sore throat. The latter symptom in patients using sulfonamides for more than one week may indicate the beginning of an agranulocytosis.

The skin should be checked for fine macular rash, which is frequently missed by the patient or his attendant. Patients should avoid direct sunlight and ultra-violet light because of a photosensitization phenomenon.

Temperature should be noted to detect drug fever.

Kidneys: Urine should be watched and measured. Minimum output should not be less than 1,000 cubic centimeters daily. Hematuria is an indication for stopping therapy.

Conclusion: With the possible exception of leukopenia or agranulocytosis, all toxic reactions can be discovered if patient is kept under careful observation. If toxic manifestations appear, these drugs should be discontinued and fluids forced to eliminate them from the system as rapidly as possible.

American College of Surgeons.—In accordance with Article III, Section 5, of the By-Laws, the annual meeting of the Fellows of the American College of Surgeons is called for 1:45 o'clock on the afternoon of Thursday, November 6, 1941, in the ballroom, Copley Plaza Hotel, Boston, Massachusetts. In addition to the routine business, reports of officers and standing committees will be presented. Each Fellow of the College is respectfully urged to be present.

Educational Program of California Tuberculosis Associations.—The annual educational program sponsored by the tuberculosis associations in California is now being planned. It is carried on in April each year, and is known as the "Early Diagnosis Campaign."

The theme for 1942, "Tuberculosis—Find it—Treat it—Conquer it," was selected by the committee of the National Association of Tuberculosis Secretaries; and the material to be used, including pamphlets, leaflets, posters, and charts, was prepared under the supervision of the committee of the American Trudeau Society.

A preview of the material impresses the reader with the modern trends in health education literature. Attractive titles, handsome layouts and printing jobs, and easy-to-read content, characterize this new packet of educational material.

Such titles as "Element'ry, my dear Holmes, element'ry," "Let's Take 2 Minutes to Check," "How Not to Save $300," "Puzzles Are Easy—If One Knows the Answers," all draw attention to the cleverly worded and profusely illustrated pamphlets designed for distribution to the various community groups.

These educational programs are coöperative efforts of local physicians, official health agencies and volunteer citizen groups to find unknown cases of tuberculosis and bring them to treatment; to educate the public on the need for concerted action in order to cut down the toll which this disease takes each year.

The work is supported by the annual sale of Christmas Seals which, this year, opens on November 24.

Undermining Medical Practice.—If it were not so serious, one could derive a certain amount of amusement from the clamor that periodically arises when some branch of medicine is encroached upon by nonprofessionals and is tolerated and even encouraged by the law. In the years gone by ophthalmology has given birth to the optometrist and optician. General practice has sired the physiotherapist. Anesthetists are responsible for the large number of nurses who have intruded into the specialty. There has even been a movement to qualify laymen as "audiometrists" who would be eligible to test hearing with an audiometer.

We, as a whole, have no one but ourselves to blame for this situation. It is a result of carelessness, but more so of indolence in the performance of the time-consuming details attendant upon every branch of medicine. Others have been quick to see the lucrative possibilities of these stepchildren of medicine. They have had our unconscious support in the development of these fields during the past decade and a half, when the medical profession was intense in the encouragement of specialization.

When the world depression began to affect the income of physicians, it began to dawn upon us that we had relinquished a considerable source of revenue which rightly belonged to the doctor. Rectification of the situation was impossible. There are still fields in which there is a tendency to relegate medical functions to laymen. In radiology, dermatology, and orthopedics—to name a few—one sees this inclination all the time. If we are not to be further encroached upon, it is up to us, and us alone, to stop it.—*N. Y. Jour. Med.*, October 1, 1941.

Los Angeles County Examination for Physician.—A $275 a month position in Los Angeles County is seeking a qualified physician to fill it, according to an announcement just made by the Los Angeles County Civil Service Commission.

The position is that of physician, M. D. (communicable disease) in the County Health Department, and the Civil Service Commission has announced an open competitive examination with the usual three-year county residence requirement waived in order to obtain the most competent man for it. Candidates must be not over forty-five years of age, have been graduated from an approved medical school, and have completed a one-year internship in an approved hospital. A residency or second year of internship, including service in a communicable disease unit, is desirable, as is experience in public health work.

Applications to take the examination must be filed with the Los Angeles County Civil Service Commission, Room 102, County Hall of Records, by Wednesday, November 12.

Definition of the Word "Biopsy" Is Given by The Journal of the American Medical Association.—Language is constantly changing, according to *The Journal of the American Medical Association.* The sense of a word in common usage may diverge so far from the dictionary definition that redefinition may be required.

Consider the word "biopsy." The dictionaries agree essentially in defining biopsy as the examination for purposes of diagnosis of a portion of tissue removed from the living body. Usage, however, seems to make "biopsy" mean the process of removing the living tissue rather than the examination. . . .

The following working definition will be followed in the future in the use of the word "biopsy" in publications of the American Medical Association: "The removal and examination of a piece of tissue from the living body for purposes of diagnosis (usually microscopic)." For example, the phrase "biopsy of lymph node" will mean the procedure of removal and examination, and "the biopsy showed . . ." will refer to the results of the examination as part of the whole procedure.

Federal Aid to Schools of Nursing.—Eighty-eight schools of nursing selected by the United States Public Health Service to receive federal aid in training additional student nurses have been named by Surgeon-General Thomas Parran.

Sixty-seven schools in thirty-two states will offer refresher courses to 3,000 graduate nurses, and twenty-six schools will enroll 500 graduate nurses for postgraduate study. A total of $1,200,000 is available for the program, which includes field-training centers for public health nursing.

The student-nurse training program will increase enrollment by 2,000 young women in this country, Hawaii, and Puerto Rico. Surgeon-General Parran has estimated a need for 50,000 student nurses this year, and the federal program will bring the total to about 42,000. The average yearly enrollment is slightly under 40,000. It is hoped schools able to increase their enrollment without federal aid will meet the deficiency. . . .

California schools in the list include: Santa Clara Hospital School of Nursing, San Jose; Los Angeles County General Hospital School of Nursing, Los Angeles.

Pharmacological Items of Potential Interest to Clinicians.—An informal bulletin from the University of California Department of Pharmacology reports:

1. *From Neighboring Americans:* Well-developed new periodical, *Revista Medica Municipal* (Rio de Janeiro) carries neat report by J. Goulart on KCl by mouth for relief of congestive cardiac edema (1:681, 1941). J. Bullo (Rev. Neurol., Buenos Aires, 6:16, 1941) surveys Takata-Ara reaction in cerebrospinal fluid. A. Stabile (Arch. Urug. Med. Cirur. Espec., 18:79, 1941) shows estrone increases tone of insufflated fallopian tubes, while progesterone diminishes it. M. Robortella (Arq. Cirur. Clin. Exper. Sao Paulo, 5: Suppl. 1, 1941), describes significance of Lemos Torres' sign in diagnosing pleural effusion when x-ray is inadequate. B. A. Houssay, E. B. Del Castello, and A. Pinto (Rev. Soc. Argent. Biol., 17:26, 1941) confirm corticosterone inhibition of thymus, finding adrenal cortex extirpation produces thymic and lympathic hyperplasia inhibited by cortex or gonad hormone administration. From Houssay's always productive laboratory comes also a full discussion with Francis S. Smyth and V. G. Foglia of the diabetogenic action of anterior pituitary extracts from different animals (*ibid.*, p. 5). G. C. Bertani (Rev. Aso. Med. Argent., 55:367, 1941) reviews gold therapy in chronic rheumatism. F. F. Rocca and A. G. Falcone (*ibid.*, p. 434) report estrone helpful in hyperthyroidism. For full index of current Latin-American medical periodicals, see back pages of each issue of *Revista Medica Latino-Americana* (Buenos Aires); you may be surprised.

2. *Personal:* Note with regret the death of A. J. Clark, Professor of Pharmacology at Edinburgh, author of useful "Applied Pharmacology" (eighth edition, just issued), and leading contributor to modern pharmacological theory (Mode of Action of Drugs on Cells, Balt., 1933; General Pharmacology, Hdb. Exper. Pharmakol., Erganz. Bd. 4, Berlin, 1937). Clinicians desiring to understand some of the factors involved in "Variations in the Individual Response to Drugs" would do well to read his article of that title (Edin. Med. Surg. J., 42: Trans. Med. Chir. Soc., January, 1935). Available for research contact deserved and desired: Nobel prizeman O. Loewi in New York; P. Pulewka, Professor of Pharmacology at Ankara; Tiffeneau's Parisian associate, M. R. Cahen, in care of P. Vandewiele, Chateauroux, India; E. Starkenstein, Amsterdam; H. Handovsky, Ghent, and A. Rabbeno, Torino. From the Drug Addiction Committee of the League of Nations, P. J. O. Wolff has gone to Buenos Aires. H. H. Anderson and I. Snapper have returned to their posts at Peiping Union Medical College.

3. *Tooting Our Own:* J. G. Hamilton, M. H. Soley, and K. B. Eichorn report on distribution of radio-iodin in human thyroid tissue, showing concentration in hyperplastic areas (Univ. Calif. Publ. Pharmacol., 1:339, 1940). A. Palmer discusses bio-assay of estrogens in ovariectomized mice (*ibid.*, p. 375). J. L. Morrison finds no public health hazard in use of monochloracetic acid as a food and beverage stabilizer (*ibid.*, p. 397). G. A. Alles proposes in comprehensive survey that ionic size is limiting factor in intensity of muscarine or nicotin type of action of alkyl-ammonium ions (*ibid.*, 2:1, 1941). D. F. Marsh reports on anesthetic possibilities of largest single group of potential inhalation anesthetics ever surveyed, forty-eight vinyl type brom and chlor olefins (*ibid.*, 2:39). B. E. Abreu and R. B. Aird discuss disappearance of acacia from cerebrospinal fluid (*ibid.*, 2:79).

4. *Other Notes:* G. Bohmansson and E. B. Norup (Act. Chirur. Scand., 84:427, 1941) report large amounts of serum with sulfonamide greatly improves prognosis in *diffuse* peritonitis, but not in local. G. J. Martin, M. R. Thompson, and J. Carvajal-Foreno (Am. J. Diges. Dis., 8:290, 1941) find that of the vitamin B complex, nicotinamide decreases alimentary tract motility while inositol increases it. H. M. Mackay (Arch. Dis. Child., 16:1, 1941) finds atropin methyl nitrate ("eumydrin") 0.1 to 1 milligram daily in divided doses, with feeding very helpful in hypertrophic pyloric stenosis. In H. H. Kessler's "Accidental Injuries: Medico-Legal Aspects of Workmen's Compensation and Public Liability" (second edition, Philadelphia, 1941), Chapter 19 deals with industrial poisoning, with full bibliography.

Scientific Exhibit at Next Year's Del Monte Annual Session.—Exhibits may consist of charts, graphs, photographs, motion pictures, roentgenograms, specimens, apparatus and instruments. Members of the California Medical Association are invited to correspond with the Secretary-Editor in regard thereto. Prizes and certificates are awarded for the best exhibits.

Tons of Medicine Rushed to U. S. S. R.—Chairman Norman H. Davis of the American Red Cross announced he had given instructions to forward immediately 800 tons of medical supplies now in England to the U. S. S. R. Through the coöperation of the British Red Cross, to which these supplies were consigned, immediate shipment is being made. The supplies will be replaced to the British Red Cross by similar stocks from the United States.

Coincident with this immediate aid to the war-wounded soldiers and civilians in Russia, Chairman Davis announced that an additional $250,000 worth of medical supplies will be sent direct from the United States to Russia. A shipment from this purchase is en route, containing hospital garments, surgical dressings, and large quantities of insulin and gas gangrene serum and antitoxin. The remainder of the $250,000 worth of supplies now is being readied at American ports for shipment. This will include drugs of all types, five million surgical dressings, quantities of surgical instruments and other hospital supplies.

Pay-Your-Doctor Week.—Fourth annual "Pay-Your-doctor Week" was observed this year, November 2 to 8.

Inaugurated in 1938 by California Bank in Los Angeles, observation of "Pay-Your-Doctor Week" swiftly spread to scores of cities throughout the country, and last year virtually achieved nation-wide recognition.

Primary purpose of "Pay-Your-Doctor Week" is to pay tribute to the members of the healing profession, who quietly but relentlessly continue the battle against disease and sickness, particularly at this time when much of the world is engaged in destroying rather than preserving life.

Recognized also is the fairly widespread tendency to "let the doctor wait" until all other bills have been paid.

Sponsors of "Pay-Your-Doctor Week" point out that the plight of the country doctor, who is often paid with farm products or a share in next year's crop, has been widely publicized in recent years, while little has been said about the city doctor, whose reward for services rendered all too frequently consists mainly of long hours of practice and vague promises of payment some time in the future.

Because "Pay-Your-Doctor Week" was originated and is sponsored by the banking profession, the question of medical ethics is not involved.

Banks sponsoring the week throughout the country call attention to the fact that funds are available to lend for the purpose of paying doctor bills.

Hospital Bed Facilities in the United States.—The most widespread survey ever made of hospital bed facilities in the United States has been released by the Census Bureau of the United States Department of Commerce, revealing that 1,282,785 beds were available in 9,614 institutions for the medical care of the American people in 1939.

The country's 6,991 hospitals and sanatoriums provided the great bulk of this care—355,145,063 patient-days, or the equivalent of one week-end stay in a hospital each year for every person in the United States. Infirmaries and nursing, convalescent, and rest homes provided the remainder.

Hospitals and sanatoriums had 1,186,262 beds—92 per cent of the nation's total. Census Bureau figures show that the average hospital had 169 beds and served 5,000 families. . . .

Even existing facilities are not being used fully, the Census Bureau Survey indicated. Allowing a margin of reserve for epidemic peaks, the Committee on the Cost of Medical Care estimated that general hospitals would operate most efficiently with an occupancy of 80 per cent, and mental and tuberculosis hospitals with an occupancy of 90 per cent.

In 1939, general hospitals were operating at 70 per cent of capacity, tuberculosis hospitals at 85 per cent, and mental hospitals at 95 per cent. The Census Bureau noted that many mental hospitals are overcrowded, due to rapidly increasing hospitalization for this type of illness.

Although only 594 hospitals—less than one in ten—were for nervous and mental patients, they had 602,850 beds or more than one-half of the total for all types of patient. They gave 208,466,000 patient-days of care.

The 5,912 general hospitals gave 122,467,000 patient-days of care, and the 485 tuberculosis hospitals 24,212,000 patient-days.

Approximately 77 per cent of the care rendered in 1939 was in state, local, and federal government-controlled hospitals, 20 per cent in nonprofit institutions, and 3 per cent in proprietary institutions, the Census Bureau noted. The large proportion of care financed by taxes is due to government tuberculosis sanatoriums and government hospitals for mental patients.

California was classed with eighteen other states listed as having "adequate facilities," the state being credited with 85,365 beds, equivalent to 124 beds per 10,000 population.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

A Doctor's Job

Several physicians were among the guests at a dinner party at a local home the other evening. Just as dinner was about to be served, one of them received a telephone call and left immediately. Two hours later he returned, in the meantime having performed an emergency operation for appendicitis upon a person he had never seen before. He sat down to a meal that was not so good as it had been a couple of hours earlier.

This little happening is a commonplace sample of what happens constantly in the lives of physicians. Under our present system of privately operated medical practice, physicians are always ready to aid. Somehow we have an idea that if we had some form of state medicine, as is sometimes demanded, state-paid surgeons would not be so ready to sacrifice their comfort for the benefit of their profession.

At least that is usually the way it works when bureaus and bureaucrats take over.—San Jose *News*, October 2.

* * *

Insurance Men Conclude Meet

Convention in San Francisco Goes on Record Against Socialized Medicine

San Francisco.—The current trend toward state-administered medical care and socialized medicine was condemned in San Francisco yesterday by delegates to the twenty-eighth annual convention of the National Fraternal Congress of America, representing eighty-six fraternal insurance societies with a membership of more than seven million.

Concluding its five-day sessions, the convention adopted resolutions advocating prompt and satisfactory solution of the problems of public health and medical care in a manner best befitting the American way of life. . . .

Action of the convention stemmed in part from an address on Wednesday by Charles A. Togut on the political threat to medicine. Mr. Togut, a counselor at law of New York City, warned that state or governmental medicine may destroy the private practice of medicine.

"The paralyzing strangulation of the country's 50,000,000 voters through the politically controlled and dominated doctor will be the lost horizon of merciless bureaucracy," Mr. Togut asserted. "The moment we vest in the Government the care of the body, we imprison the political soul of every voter.

"The legislatures of every state, barring four, pondered over 200 bills relating to medical and hospital care, and several states deliberated far-reaching legislation to establish state-wide plans for public medicine. The Congress of the United States is weighing the destiny of our peoples and of our doctors with numerous authoritarian legislative medical measures. The battle of the century, the Government versus the American Medical Association, is

but a prelude to the conditioning processes of a national planned medical care program—unless the American people, the doctors, the industrialists, the leaders of labor and capital can smother the most powerful propaganda factory in the world and inaugurate fighting means and methods to unite the leaders of medicine and industry in a progressive and universal health insurance movement, the merit of which could not be attacked by the most fervent advocate of socialized medicine."

Organization of a national institute of health insurance under the American Medical Association was advocated by Mr. Togut to make available immediately the medical skill and facilities of the United States to people who cannot buy medical care. Pointing out that a large market awaits this insurance, Mr. Togut said that under full acceptance annual premium income could exceed those of all legal reserve life insurance companies in the United States. . . .

Thomas R. Heaney, Secretary of the Catholic Order of Foresters of Chicago, was elected president of the fraternal congress for the ensuing year.—San Francisco *Wall Street Journal*, September 26.

* * *

Hospital Service Plan Benefits Disclosed

"Payments made to hospitals during this week and covering hospital services for our members brings the total paid out in three years to more than $500,000," reported Ralph G. Walker, executive director of the Associated Hospital Service of Southern California. "This means that this sum, which otherwise would have come out of the savings and pocketbooks of employed people in payment for unexpected hospital bills, has been paid for them through their membership in Southern California's own Hospital Service Plan."

The local Association was organized and backed by fifty-seven hospitals in Southern California.—Hollywood *Citizen-News*, September 26.

* * *

Physicians Seek Better Health Insurance

Ideas for improvement of the major health insurance systems affecting San Francisco physicians were sought at a general meeting of the San Francisco County Medical Society.

The Health Service System, under which 1,070 San Francisco physicians serve 16,274 municipal employees and their dependents, and California Physicians' Service, by which some 5,400 California doctors serve approximately 30,000 persons throughout the state, were analyzed and discussed in detail, according to Dr. Harold A. Fletcher, County Medical Society president.

Means of making these systems function more smoothly and efficiently was given careful consideration by the entire membership of the Society, Doctor Fletcher declared.

"It is vital for the continued existence of the Health Service System that it be put on a sound, businesslike basis," Doctor Fletcher declared. "Under present arrangements, the doctors are required to underwrite this system at an approximate 50 per cent loss to themselves. In justice to the doctors and for the welfare of the system and those it serves, a more efficient basis of operation must be found. The physicians are most earnest in their desire to make this an effective—in fact, a model—health insurance system."

Speakers at Tuesday night's meeting included Dr. Alson R. Kilgore, one of the founders of the California Medical Association's health insurance system.—San Francisco *Sunset News*, September 25.

* * *

Food Sale as Public Utility Is Proposed

San Francisco, September 27 (AP).—An initiative constitutional amendment designating the sale of all food a public utility and vesting in the state the exclusive right to sell food to the public was sent to the Secretary of State today by Avery C. Moore of Oakland, with the request that a copy be forwarded to the Attorney-General for titling.

The proposed amendment would create a state board of food distribution which would purchase food and sell it at cost to the people. It would prohibit food sale by private agency for profit.

Moore said the proposed amendment is intended as a companion initiative to the free medical care initiative, of which he also is the proponent.—Sacramento *Bee*, September 27.

* * *

Warren Rules Relief Camps May Continue

Attorney-General Earl Warren's office today ruled that relief camps established by the defunct State Relief Administration may continue to operate, using supplies already on hand and funds provided by the counties and the Work Projects Administration.

The Medical Practice Act does not require that applicants for licenses as physicians and surgeons, including those holding credentials from foreign medical schools, shall have done all their work in one school. . . .—Sacramento *Bee*, October 10.

* * *

State Health Officers Accused of Failing to Coöperate

Sacramento, October 13 (Special to The News).—A blistering attack on California health officers for failing to coöperate more closely and to arouse greater interest in matters of public health was delivered today by Dr. Lee Alexander Stone, Madera County health officer, at a meeting of the Health Officers' Section, League of California Cities. Doctor Stone, President of the Section, warned that social workers are making inroads in public health fields, are highly organized and, "unless curbed, all of us may find ourselves out on a limb with a social worker directing our actions."

"Save for Bay Region politicians," said Doctor Stone, "I know of no health officer group in California that cares a damn about the welfare of their confrères.

"Doctors as a class are too selfish as far as professional relationships with other groups are concerned. They rarely (there are a few exceptions) interest themselves in what is going on about them except only as it concerns themselves. Their opinions must be regarded as being sacrosanct or else they go into a corner and pout.

"We meet once a year as a health officers' organization. We hear a few papers read and, if interested, enjoy discussing them. We have a good time, give a dry banquet, not because we want to particularly, but because we are afraid of offending reform groups.

"If we are to defeat self-constituted groups bent on taking from us the very little we now have, we should organize.

"Let's forget our own political sensitiveness and determine to have unity for the sole purpose of making the state alive to our existence. Legislation needs to be passed that will place public health and public health officials on a sound economic footing."

* * *

Los Angeles Scientist Gets Coveted British Medical Award

Dr. Arthur E. Guedel Honored for Work in Anesthesia

Dr. Arthur E. Guedel, scientist in the field of anesthesia, last night received the prized Henry Hill Hickman Medal awarded by the Royal Society of Medicine at London. He was the third person in the world and the only American to be so honored.

The presentation, with Gilbert Holliday, British Vice-Consul, acting on behalf of the Royal Society, was made at a dinner tendered Doctor Guedel by the Los Angeles County Medical Association—and was done without the bronze medal itself, "due," Holliday explained, "to unfortunate interruption of shipping schedules."

History Reviewed

Introduced by Dr. Thomas Chalmers Myers, president, Dr. Chauncey Leake, University of California professor of pharmacology, reviewed the history of anesthesia. He described Hickman, a young British surgeon of the last century, as "the first man to undertake, by systematic experiments and study, the use of gases in getting relief from pain in surgical operations."

Doctor Guedel was lauded for "pioneering the reintroduction of nitrous oxid as an anesthetic by making it safe from asphyxiation by adding plenty of oxygen"; for developing divinyl ether—"a safer agent and a faster one than ordinary ether"; for aiding in creation of the carbon dioxid absorption method that "reduces explosions and gives better control to the surgeon," and for twelve years' research in the perfection of cyclopropane gas.—Los Angeles *Press Item*, October 22, 1941.

* * *

Rôle of Mongrel Dogs: A Fat-Burning Hormone Is Discovered

Chicago, October 10 (The Special News Service).—Some mongrel dogs kept at the University of Chicago have helped science discover a new chemical which burns up fat in living bodies.

The chemical is a new hormone, which has been named Lipocaic, after two Greek words, lipos, meaning fat, and kaio, meaning I burn.

This hormone is a companion of insulin. Both are manufactured in the pancreas, the gland which lies near the stomach. Lipocaic is useful in some of the fat disturbances of diabetes, and has cured a few cases of the supposedly incurable skin disease, psoriasis.

In the rôle played by the Chicago dogs, scientific history has repeated itself. Dog experiments enabled the late Sir

Frederick Banting to discover insulin, which has saved millions of lives in a few years.

Live for Science

Whereas laboratory animals popularly are supposed to die for science, the Chicago dogs may be said to have lived for science. All are animals which had gone to the dog catcher and were about to be put to death.

The Chicago experimenters gave these animals new leases on life. One of them, which came into the laboratory when the first experiments began, still is doing his bit.

In these animals, lipocaic was shown to be a good remedy for fatty livers. This is an affliction which sometimes complicates diabetes. One of the first human cases treated for this trouble, a 59-year-old woman, was improved by the new hormone.

Seven Were Cured

The skin disease, psoriasis, was attributed by medical scientists to faulty utilization of fat by the body. For this reason the fat-burner hormone was tried on twenty-two persons. Of these, seven were apparently cured, eleven were improved, and four were not benefited.

The lipocaic has helped another skin trouble, zanthomatisis, in which nodules appear on the body. This disease is attributed to fat in the blood.—San Francisco *Chronicle*, October 11.

* * *

Arrangements Should Be Made in Advance for Children's Clinic

Arrangements should be made in advance for physically handicapped children to attend the clinic in the Veterans' Memorial Building, Sonora, Tuesday, September 23, from 1 to 4 p. m. Appointments can be made through Miss Thelma Jordan, public health nurse.

The clinic is under the auspices of the Crippled Children's Services of the State Department of Public Health.

All children under twenty-one years of age who are crippled by disease, accident, or by deformities present at birth, are eligible to attend the clinic, which is one of a series held annually throughout California by the State Department of Public Health.

Last year the State Department held forty-seven diagnostic clinics in different sections of the state, at which 1,828 crippled children were examined and recommendations made for medical care.—Sonora *Union Democrat*, September 19.

* * *

$75,000 Grant From Rockefeller Foundation Will Finance Three-Year Study of Health Agencies in United States

The National Health Council, which has served for the past two decades as a clearing house for national voluntary organizations promoting better health, is undertaking a comprehensive study of the activities of all private health agencies in the United States, under a special grant of $75,000 from the Rockefeller Foundation, it is announced by Dr. Kendall Emerson, president of the Council.

"Great strides have been made in health education during the past twenty or thirty years," said Doctor Emerson, "and the American public has come to understand that it is much more economical, as well as far more humane, to prevent disease than to cure it. Communities throughout the country have built up many excellent private health services devoted to the prevention of illness, and we have now reached a point where it seems desirable to appraise this whole field of endeavor in order that our efforts may be even more effective.

"The study will take about three years to complete, and the report will answer such broad questions as the following: What are the various types of state and local voluntary health agencies? What fields do they cover? What methods of coöperation with official health agencies have they established? What do they cost to operate? What types of health work lead to the greatest active participation on the part of the citizens?"

Dr. Louis I. Dublin, chairman of a special committee of the National Health Council, which has been making plans for this study, said: "It is particularly appropriate that the Rockefeller Foundation should finance such an undertaking, for it was the support of the Foundation which made possible the establishment of the National Health Council in 1921, and since then the Foundation has shown unmistakable interest in various Council activities. We are especially pleased that the Foundation has met our request to grant a leave of absence to its vice-president, Mr. Selskar M. Gunn, one of the wor'd's outstanding authorities on public health problems, to direct this study."

Mr. Gunn returned to America recently after a long stay abroad as director of the European headquarters of the Rockefeller Foundation in Paris, now closed because of the war. Previously, he had been in charge of the Foundation's program of rural reconstruction in China.

The active members of the National Health Council (headquarters at 1790 Broadway, New York City), include the following: American Red Cross, American Public Health Association, American Eugenics Society, American Heart Association, American Social Hygiene Association, American Society for the Control of Cancer, American Society for the Hard of Hearing, Conference of State and Provincial Health Authorities of North America, Maternity Center Association, National Committee of Health Council Executives, National Committee for Mental Hygiene, National Organization for Public Health Nursing, National Society for the Prevention of Blindness, and the National Tuberculosis Association.

There are two associate members, the American Nurses' Association and the Foundation for Positive Health; and there are two advisory members, the United States Children's Bureau, and the United States Public Health Service.

MEDICAL EPONYM

Bence-Jones Protein

A paper, "On a new substance occurring in the Urine of a patient with Mollities Ossium," was read before the Royal Society on April 22, 1847, by Henry Bence-Jones (1813-1873), physician to St. George's Hospital. This appears in the *Philosophical Transactions of the Royal Society of London* (138, Pt. 1:55-62, 1848).

On the 1st of November 1845 I received from Dr. *Watson* the following note, with a test tube containing a thick, yellow, semi-solid substance:—'The tube contains urine of very high specific gravity; when boiled it becomes highly opake; on the addition of nitric acid it effervesces, assumes a reddish hue, becomes quite clear, but, as it cools, assumes the consistence and appearance which you see: heat reliquifies it. What is it?'

"A few hours afterward a specimen of the same urine, passed by a grocer forty-seven years of age, who had been out of health for thirteen months, was sent to me by Dr. *MacIntyre*. He, being in attendance on the case with Dr. *Watson*, had two days previously first observed the peculiar reactions of the urine.

"The specimen of urine was slightly acid; specific gravity 1.034; it contained a sediment consisting of crystalline phosphate of lime, oxalate of lime, and cylinders of fibrin. The urine became thick with heat from a deposit of phosphates, but cleared with a drop of acid. It gave no precipitate with an excess of nitric acid, unless left to stand, or unless heated and left to cool, when it became solid. This solid redissolved by heat, and again formed on cooling. Continued boiling with strong nitric acid evolved but little gas, and did not quickly hinder this reaction. Hydrochloric acid gave the same solid precipitate, soluble by heat. Strong acetic acid gave only a slight precipitate which redissolved by heat. Caustic potash and sulphate of copper gave a splendid bright blue, clear liquid, passing over when heated to claret colour. . . .

"January 2nd.—The patient died. The following day I saw that the bony structure of the ribs was cut with the greatest ease, and that the bodies of the vertebrae were capable of being sliced off with the knife. For an account of the structure of the bone, see a paper by Mr. *Dalrymple* in the third number of the Dublin Journal, August 1846. . . .

"The ultimate analysis of this substance may be represented by C_{48}, H_{37}, N_6, O_{15} or C_{40}, H_{30}, N_5, O_{12}. . . . Hence it is an oxide of albumen, and from ultimate analysis, it is the hydrated deutoxide of albumen. . . .

"The peculiar characteristic of this hydrated deutoxide of albumen was its solubility in boiling water, and the precipitate with nitric acid being dissolved by heat and reformed when cold. . . .

This substance must again be looked for in acute cases of mollities ossium. The reddening of the urine on the addition of nitric acid might perhaps lead to the rediscovery of it. . . ."—R. W. B., in *New England Journal of Medicine*, Vol. 225, No. 9.

LETTERS†

Concerning Inactive Duty Training: Medical Department Reserve Officers.

(COPY)

HEADQUARTERS NORTHERN CALIFORNIA MILITARY DISTRICT
PRESIDIO OF SAN FRANCISCO, CALIFORNIA

October 28, 1941.

Subject: Inactive Duty Training, Medical Department Officers, 1941-42.

To All Medical, Dental, Veterinary, Sanitary and Medical Administrative Officers in the Northern California Military District.

1. In keeping with the policy of the War Department, for inactive duty training, during the school year 1941-42, all medical department reserve officers are enjoined to participate with the view in mind to increase their military knowledge. In this connection attention is invited to the fact that the Combined East and West Bay Special Medical School meets once a month:

Place: Building 612 (usual classroom) Presidio of San Francisco, California.

Date: Third Tuesday of each month.

Hours: 7:30 p. m. to 9:30 p. m.

2. Programs are arranged in advance, and excellent speakers are obtained. Lecture, conference and applicatory methods are used and from time to time visual methods are also employed. In these days of national emergency no officer concerned can afford to miss the available instructions.

3. Due consideration has been given to your busy personal program; however, today military obligations have priority. Concerned officers not yet called to active duty should set aside without fail the evening of the *third Tuesday* of each month for the 1941-42 school year, and officers now on active duty who can attend without interfering with their duties are cordially invited to be present.

(Signed) HAROLD R. HENNESSY,
Major, Medical Corps Unit Instructor.

Concerning California Laws in re Foreign Medical Graduates.*

(COPY)

BOARD OF MEDICAL EXAMINERS: STATE OF CALIFORNIA

San Francisco, California,
October 7, 1941.

Yours of October 3, re Dr. ———, Foreign Medical School Graduate.

Dear Doctor:

This will acknowledge receipt of your letter written in behalf of Dr. ———, who you state is a graduate of a medical college in Czecho-Slovakia.

The 1941 legislature passed Chapter 751, Statutes 1941, wherein, among other requirements exacted of foreign medical school graduates, is one reading in part as follows:

"If the applicant is not a citizen of the United States (it will be necessary for him to show satisfactory evidence that) the country in which he has been admitted to practice medicine and surgery will admit to practice therein citizens of the United States, upon proof of prior admission to practice medicine and surgery in some state of the United States, or upon proof of matters similar to those required in this section for graduates of foreign medical schools."

If Dr. ——— is able to show satisfactory evidence of the requirements mentioned above, it will then be necessary for him to complete a one-year rotating internship in a hospital approved for the training of interns anywhere in the United States.

Trusting that this is the information you desire, believe me

Very truly yours,
C. B. PINKHAM, M. D.,
Secretary-Treasurer.

Concerning Official Agencies in Civilian Defense.*

(COPY)

Executive Office of the President
OFFICE FOR EMERGENCY MANAGEMENT
WASHINGTON, D. C.

OFFICE OF CIVILIAN DEFENSE
233 Sansome Street, San Francisco
Telephone: EXbrook 2751

October 1, 1941.

To the Editor:—I am enclosing a copy of Doctor Baehr's letter and the joint statement of the Office of Civilian Defense and the Red Cross. We would appreciate your printing any or all of it in CALIFORNIA AND WESTERN MEDICINE. Doctor Baehr thought the second paragraph of his letter, without the introductory phrase, would be sufficient, but you can use your own judgment. Use as much or as little of it as you see fit.

Your outline of the Los Angeles preparedness for disaster interests me a great deal. I feel that I could profitably study their plan with the thought in mind that much of it might be adopted by other cities. Doctor Baehr was of the same opinion and has requested that I make a full report on the Los Angeles plan. Perhaps you could advise me who I should see there to direct my study. I would appreciate any help you can give me in this matter.

Cordially,

(Signed) WALLACE D. HUNT, M. D.,
Regional Medical Officer.

* * *

(COPY)

OFFICE OF CIVILIAN DEFENSE
WASHINGTON, D. C.

September 22, 1941.

To Chairmen, State Defense Councils
Attention: Health and Medical Committees

Numerous requests have been received by the Medical Division of the Office of Civilian Defense from Health and Medical Committees of state and local defense councils for a definition of the rôle of Red Cross Chapters in the local program. The enclosed statement, issued jointly on September 4 by the U. S. Director of Civilian Defense and the Chairman of the American National Red Cross, supplies this information. I would request that this joint statement be transmitted to your local defense councils and local Chiefs of Emergency Medical Service.

According to this statement, the state and local defense councils are the official agencies responsible for the coordination of all available resources which may be required for civilian protection in the event of belligerent action. Defense councils should, therefore, acquaint themselves with the resources of the local Red Cross Chapters in providing food, clothing, shelter, nursing care, transportation, and other basic necessities and should integrate them into the comprehensive local program. Duplication of trained and experienced personnel and of available supplies

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

* Editor's Note: The Board of Medical Examiners of the State of California issues a leaflet (Form 173) with "Instructions to Graduates of Foreign Medical Schools."

* For editorial comment, see page 226.

of the Red Cross should be avoided except where supplementation is essential to meet the anticipated needs of the community.

Very truly yours,

(Signed) GEORGE BAEHR, M. D.,
Chief Medical Officer.

* * *

(COPY)

The Director of the Office of Civilian Defense and the Chairman of the American National Red Cross recently issued the following joint statement to clarify the responsibilities of the two agencies in civilian defense activities.

1. The Office of Civilian Defense is the official Government agency "to assure effective coördination of federal relations with state and local governments engaged in defense activities, to provide for necessary coöperation with state and local government in respect to measures for adequate protection of the civilian population in emergency periods, to facilitate constructive civilian participation in the defense program, and to sustain national morale." (See "Local Organization for Civilian Protection," issued by the U. S. Office of Civilian Defense, July 17, 1941.)

2. The American National Red Cross is the responsible agency for relief of suffering caused by disaster, both in peacetime and in the national defense emergency, by providing food, clothing, shelter, medical and nursing care, and other basic necessities. Therefore, Red Cross Disaster Relief Service, nationally and in local chapters, will serve in emergency care and rehabilitation of individuals and families suffering from disaster caused by belligerent action during the national defense emergency in coöperation with governmental agencies—national, state, and local. In rescue work and emergency medical service caused by belligerent action by which the Office of Civilian Defense assumes leadership and responsibility, the Red Cross will make its services available as needed. (See "Disaster Preparedness and Relief—Manual for Chapters," ARC 299, issued by the American Red Cross.)

3. The Red Cross "acts as a medium of communication between the people of the United States of America and their Army and Navy." Cases of active service and ex-service men and their families should be referred to the Red Cross, which is responsible for providing or securing the service and assistance needed. In carrying out these services the Red Cross makes maximum use of other community resources.

4. Training of Office of Civilian Defense workers in first aid and nurse's aide service is provided by the Red Cross through its programs of training in first aid and nurse's aide courses. The recognized service of the Red Cross in training industrial workers and others in first aid is drawn upon.

5. The Red Cross, through its chairman as a member of the Civilian Protection Board, has made available all of its services as needed by the Office of Civilian Defense, both national and local.

6. Councils of Defense and Red Cross Chapters in their civilian defense activities should develop their local plans of coöperation in accord with this joint statement of responsibility.

(Signed) F. H. LAGUARDIA,
U. S. Director, Civilian Defense.
NORMAN H. DAVIS,
Chairman, American National Red Cross.

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.
San Francisco

Releases: Effect of Release Given by Injured Employee to Employer and Insurance Carrier; Release Does Not Preclude Malpractice Action

It is a general rule of law that a release given by an injured person to one of several persons jointly causing his injury has the effect of releasing all persons. Usually the rule is stated as follows: "The release of one joint tort feasor releases all." As so-called malpractice actions are tort actions, it follows that where more than one person is claimed to have caused injury to a patient, a release given to one releases all. (For a more detailed discussion, see CALIFORNIA AND WESTERN MEDICINE, August, 1938, p. 171.)

The following is a hypothetical case illustrating the foregoing rule: Mr. X undergoes a major operation at the White Hospital (not a charitable hospital); surgery is performed by Dr. A, who is assisted by several nurses employed by the hospital. One nurse neglects properly to count the sponges, resulting in a sponge being left in the patient's body. Assuming negligence, the persons liable would be Dr. A, as the surgeon, the nurse, and the White Hospital. If the patient, Mr. X, should sign a written release releasing the nurse, such release would also have the effect of releasing both the physician and the hospital.

A far different situation is present in those instances in which negligence is involved in the treatment of an employee injured during the course of his employment. An injured employee has, of course, a right to claim compensation under the Workmen's Compensation Act against his employer and his employer's insurance carrier. Under the Compensation Act, if the original injury is aggravated because of medical treatment furnished at the expense of the employer or his insurance carrier, the injured employee may claim additional compensation for such aggravated injury.

Assuming that an injured employee is negligently treated by a physician selected by his employer's insurance carrier, and assuming that such treatment aggravates the original injury, then the question arises: If the injured employee releases his employer and insurance carrier from liability under the Workmen's Compensation Act, does such release also operate as a release of the physician?

In *Smith* vs. *Coleman*, 46 A. C. A. 560, decided August 15, 1941, the foregoing question was answered in the negative. In that case the defendant physician had treated a fractured little finger which had been injured during the course of plaintiff's employment. The plaintiff had claimed compensation before the Industrial Accident Commission and had settled his claim, giving his employer and employer's insurance carrier a written release. He then commenced a malpractice action against the physician, alleging negligent treatment of the fractured finger. The physician claimed that the release given to the employer and insurance company operated as a release of any claim for malpractice as against him. The District Court of Appeal rejected this contention and stated:

> The present action is not a claim under the Workmen's Compensation and Safety laws. The release was effective only as to plaintiff's employer and the insurance carrier, and did not bar his action against defendant for the separate and subsequent injury which was caused by defendant's malpractice.

The decision of the Court was based upon the fact that the physician and the employer and insurance carrier were not *joint* tort feasors. The employer and insurance carrier were not in any manner liable in tort for the act of the physician. Their liability was one for compensation under the Workmen's Compensation Act, which is a special liability not dependent upon negligence or wrong. Accordingly, the release of the employer and insurance carrier was not a release of a liability for tort and, hence, could not inure to the benefit of the physician, whose liability, if any, was necessarily a tort liability.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XIV, No. 11, November, 1916

EXCERPTS FROM EDITORIAL NOTES

Industrial Accidents.—The report of the Industrial Accident Commission for the year 1915 is interesting. The crude figures, taken from an analysis of the report as published in the San Francisco *Recorder*, are as follows:

"There were reported 67,538 injuries, as follows: Fatal, 533; permanent, 1,264; temporary, 65,741.

"The total payments for the above injuries, reported up to June 30, 1916, amounted to $2,002,706.04. This sum was apportioned between: Compensation to injured, $1,150,-503.56; medical payments, $852,202.48.

"There were 13,254 injuries out of the 67,538 that lasted 15 days and over." . . .

Malpractice: A Curious Coincidence.—The establishment of the Malpractice Indemnity Fund and the circular letter which was sent out to all members have resulted in a very large correspondence on the subject. Some of this will be referred to in another note. Singularly enough, in one mail came two very interesting letters:

1. A member of the Society wrote in, saying that he had been in practice 25 years; that he did not lack confidence in his skill and judgment; that he was never careless or negligent; that he had never been sued and did not expect ever to be sued; so that while he highly commended the plan, he would not participate in it himself.

2. The second letter was written by a member living less than twenty miles from the residence of the writer of the first letter, and was written in great agitation of mind. The writer stated that he had been in practice 26 years, that he had always been careful and faithful in his work, but that the day before he had been served with papers in a suit demanding $20,000 damages. Unfortunately for the writer of this second letter, he had not paid his dues to his county society at the time he treated the patient suing him, and therefore he was obliged to defend the suit at his own expense.

"No man knoweth the day or the hour."

The Indemnity Fund.—On October 17, the date of writing, 212 members had contributed to the indemnity insurance fund. With these contributions have come volumes of comment, practically all favorable, and much of it very enthusiastic. One inquiry is directly pertinent. Why does the plan request the sending of a note, and why does not the note state the purpose?

The first point here may be answered by saying that the object of requiring a payment for each of two consecutive years, cash for the first payment and the note for the second, is to maintain the interest of the contributors in the first place, and in the second, to distribute the money payment over two years and not concentrate it in one payment of $30.

The second question may be answered by saying that a promissory note, to be a negotiable document, must be an unconditional promise to pay a certain sum of money to order of bearer. Any alteration of the form of the note immediately destroys its negotiability. . . .

(Continued in Front Advertising Section, Page 16)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.
Secretary-Treasurer

News

"Federal Judge Michael J. Roche discharged a jury in the trial of C. A. Isbell and Mr. and Mrs. Fred Mandeville of Colfax, Placer County, on charges of using the mails to defraud, when it was unable to reach a verdict after deliberating for nearly three hours. The retrial date will be set for October 6. The defendants were accused of using the mails to advertise a cure-all for cancer, diabetes, venereal diseases and other ailments. . . ." (Sacramento *Bee*, September 18, 1941.)

"Shortly before he was to be sworn in as a medical officer in the United States Navy, Dr. Walter W. Webb, thirty-five, formerly of Seattle, was arrested in Vallejo yesterday by Federal narcotics officers on charges of selling drugs. In a removal complaint filed before United States Commissioner Ernest E. Williams by Assistant United States Attorney James T. Davis, Webb was charged with sales of morphin and cocain in Seattle between last June 28 and July 1. He was brought to San Francisco County jail and held in lieu of $1,000 bail." (San Francisco *Examiner*, September 7, 1941.)

"Christopher North received a five months' sentence in the county jail Friday, after being convicted by Judge J. G. Null on a charge of practicing chiropody without a license. . . ." (Redding *Record*, September 13, 1941.)

"The state prison board has notified Superior Judge Gordon Thompson that Dr. George H. Parchen, former local chiropractor, and his brother, Frank McKinley Parchen, must serve fifteen years in San Quentin prison. They were convicted here of second-degree murder and participation in an illegal operation. In July, 1939, Thompson sentenced them to indeterminate sentences. . . ." (San Diego *Tribune-Sun*, September 17, 1941.)

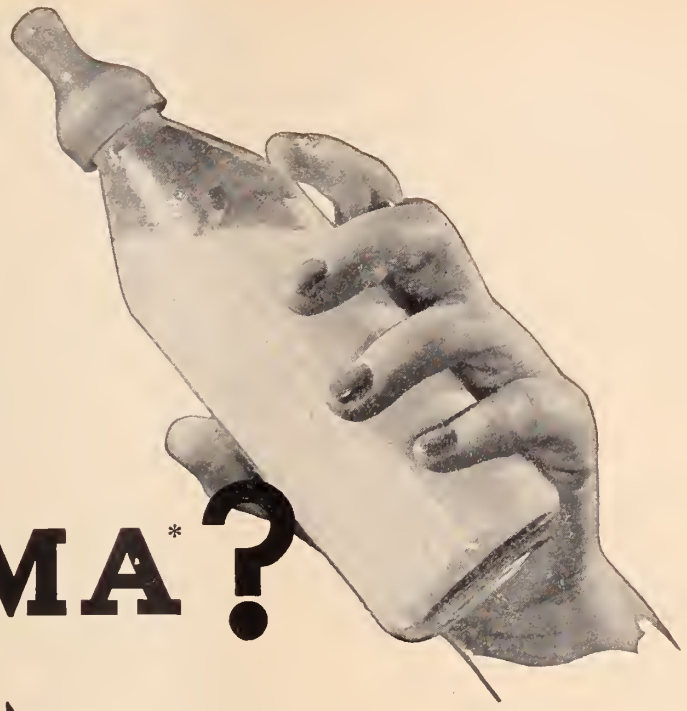
"Special Agents for the State Medical Board yesterday charged two men with practicing medicine without a license. They were Eugene L. Thurston, fifty-nine, of 610 Hyde Street, and Henry A. Jotz, thirty-five, 889 Geary Street. . . ." (San Francisco *Examiner*, September 13, 1941.) Thereafter the San Francisco *Chronicle* of September 30 carried a notice of the suicide of Thurston.

"Dr. Carl G. Williams, Santa Monica physician, will be arraigned in Department 41 of the Superior Court Monday on a charge of assault with a deadly weapon. Doctor Williams, accused of firing a pistol at a housemaid, and an attorney, and later holding at bay a group of West Los Angeles policemen when they answered a call to his home at 580 Moreno Avenue, Brentwood, was held to answer to the superior court after a preliminary hearing in West Los Angeles municipal court. . . ." (Santa Monica *Outlook*, September 27, 1941.)

(Continued in Back Advertising Section, Page 30)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News items are submitted by the Secretary of the Board.

EVER FEED SMA*?



When you prescribe S.M.A. for the bottle-fed infant you give an easily digested fat, a protein that provides the amino acids essential for adequate nutrition and growth and *lactose,* a physiological carbohydrate, in correct proportion to the nutritional requirements of the normal full-term infant.

In addition, when prepared according to the usual dilution for feeding, each quart of S.M.A. contains:

7500 international units vitamin A activity
200 international units vitamin B_1
400 international units vitamin D
10 mg. Iron and Ammonium Citrate

S.M.A. provides easily digested fat and protein of full biological value in correct proportion to the nutritional requirements of the normal full term infant. Therefore, the only carbohydrate in S.M.A. is Lactose . . .

Normal infants relish S.M.A. . . . digest it easily and thrive on it.

" " "

*S.M.A., a trade mark of S.M.A. Corporation, for its brand of food especially prepared for infant feeding—derived from tuberculin-tested cow's milk, the fat of which is replaced by animal and vegetable fats, including biologically tested cod liver oil; with the addition of milk sugar and potassium chloride; altogether forming an antirachitic food. When diluted according to directions, it is essentially similar to human milk in percentages of protein, fat, carbohydrates and ash, in chemical constants of the fat and physical properties.

ACCEPTED by AMERICAN MEDICAL ASSN. Committee on Foods

FOR PREMATURE AND UNDERNOURISHED INFANTS
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PROTEIN S.M.A.
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Protein S.M.A. (acidulated) is a modified form of S.M.A., intended to meet the special nutritional needs of the premature and undernourished infant and for infants requiring a high protein intake.

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Johnnie Walker *has* to be two people. For the friendly gentleman identifies both 12-year-old Black Label and 8-year-old Red Label Scotch whisky. Each has the smooth, friendly flavour that brings a special feeling of satisfaction to your taste. You'll like mellow Johnnie Walker, from the very first sip.

BORN 1820 . . .
still going strong

WHEREVER YOU ARE
IT'S SENSIBLE TO STICK WITH

JOHNNIE WALKER

BLENDED SCOTCH WHISKY

BLACK LABEL 12 YEARS OLD

BOTH 86.8 PROOF

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Accuracy
Quality
Reliability

The Owl Drug Co

130 STORES ON THE PACIFIC COAST

TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 26)

antigen, belongs the credit of having rendered the test available for clinical purposes. A careful perusal of the literature, concerning the practical value of the test, reveals the following facts. . . .

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 278)

"Dr. Nathan S. Housman, San Francisco physician, convicted on six counts of perjury and falsification of evidence two years ago, moved into the shadow of San Quentin prison yesterday when the United States Supreme Court declined to review his case. The physician, whose felony conviction grew directly from a misdemeanor charge of omitting to keep proper records of narcotics prescriptions, has now exhausted virtually every legal possibility in his fight to avoid imprisonment. Even before serving a day's prison sentence, he appealed to Governor Olson for pardon—an appeal which has brought an adverse recommendation from the Advisory Pardon Board. Unless the Governor acts counter to that recommendation, Doctor Housman must begin serving his indeterminate sentence. The physician's difficulties with the law began when he was accused of negligence in keeping his narcotics prescriptions. He won acquittal at his first trial; but John J. McMahon, Assistant District Attorney who prosecuted, went before the Grand Jury with charges that the acquittal had been based on 'faked' evidence submitted by the physician. Indictments followed. Meanwhile, Dr. Housman had been tried on additional charges of omitting to keep proper records. The second trial resulted in a conviction on three counts, and Dr. Housman served a

(Continued on Page 32)

S·I·M·I·L·A·C

● *The name is never abbreviated; and the product is not like any other infant food—notwithstanding a confusing similarity of names.*

The fat of Similac has a physical and chemical composition that permits a fat retention comparable to that of breast milk fat (Holt, Tidwell & Kirk, Acta Pediatrica, Vol. XVI, 1933) . . . In Similac the proteins are rendered soluble to a point approximating the soluble proteins in human milk . . . Similac, like breast milk, has a consistently ZERO curd tension . . . The salt balance of Similac is strikingly like that of human milk (C. W. Martin, M. D., New York State Journal of Medicine, Sept. 1, 1932). *No other substitute resembles breast milk in all of these respects.*

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods

A powdered, modified milk product especially prepared for infant feeding, made from tuberculin tested cow's milk (casein modified) from which part of the butter fat is removed and to which has been added lactose, vegetable oils and cod liver oil concentrate.

★ SIMILAC } SIMILAR TO BREAST MILK ★

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SAN FRANCISCO · PORTLAND, ORE. · OAKLAND · LOS ANGELES
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INTERNAL MEDICINE INCLUDING FUNCTIONAL AND ORGANIC NERVOUS SYSTEM DISEASES
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Address: STEPHEN SMITH, M. D., F. A. C. P.; CHARLES W. THOMPSON, M. D., F. A. C. P.
MEDICAL DIRECTORS, PASADENA, CALIFORNIA

BOARD OF MEDICAL EXAMINERS

(Continued from Page 30)

short term in the county jail after carrying an appeal to the superior court." (San Francisco *Examiner,* October 14, 1941.)

"Dr. Edward Marineau, thirty-six, chiropractor, and his nurse, Mabel Wilson, forty-two, were arrested yesterday by Deputy Sheriffs investigating a 'huge Hollywood illegal operation ring.'" (Press dispatch dated Hollywood, October 7, 1941, and printed in the San Francisco *Call-Bulletin,* October 7, 1941.)

Speech Defects of Children.—The causes for sound substitutions or omissions in words in the speech of young children may be both functional and organic, Ruth E. Beckey, Ph. D., Columbus, Ohio, says in a recent issue of *Hygeia, The Health Magazine.* Fortunately, she adds, many of the substitutions are due to faulty training, too much isolation, overstimulation, defective models for imitation and too much criticism by the parents. However, many of the organic defects of the speech apparatus may be repaired if the child is taken to the surgeon or orthodontist (dentist who specializes in prevention and correction of irregularities of the teeth) early enough. The teeth may need to be straightened before the child can say some of the sounds. If the front teeth have not yet appeared, and the "s" is defective, the best plan is to wait for the teeth to appear. The "s" may take care of itself. If hearing is suspected to be defective, an audiometer (device to test the power of hearing) check should be made to determine whether the child is hearing all of the different speech sounds accurately. The parents should also try to remove any unfavorable factors in the child's environment which may be impeding his progress, Doctor Beckey warns.

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Tells of Symptoms of Spinal Abscess.—A sequence of symptoms and signs important in arriving at the early diagnosis of acute spinal epidural abscess (situated on the outside of the outermost membrane enveloping the spinal cord) which is necessary if the patient is to receive the prompt treatment required to prevent lifelong disability or death, are outlined by Saul Boharas, M. D., and Y. D. Koskoff, M. D., Pittsburgh, in *The Journal of the American Medical Association* for September 27.

The two men say the condition is a disease which is rarely diagnosed before the onset of irreparable damage to the spinal cord and that the true nature of the process is often discovered only at postmortem examination.

"The diagnosis," they say, "is easy to make if the following sequence of events is considered: (1) a history of preëxisting infection or spinal trauma [injury]; (2) a latent period between this and the time of onset of pain; (3) the development of severe pain in the back, signs of acute infection and spinal tenderness; (4) a latent period between the pain in the back and the onset of neurologic [of nerve origin] signs and symptoms, and (5) the development of signs of involvement of the cord or meningitis [inflammation of the membranes enveloping the spinal cord and brain] and symptoms leading to paralysis or meningitis."

Medical Eponym

Kahler's Disease.—Professor Otto Kahler (1849-1893) of Prague first directed attention to the association between Bence-Jones proteinuria and multiple myeloma in a paper, "ZurSymptomatologie des multiplen Myeloms: Beobachtung von Albumosurie [On the Symptomatology of Multiple Myeloma: Observation on Albumosuria]," that ap-

(Continued on Page 36)

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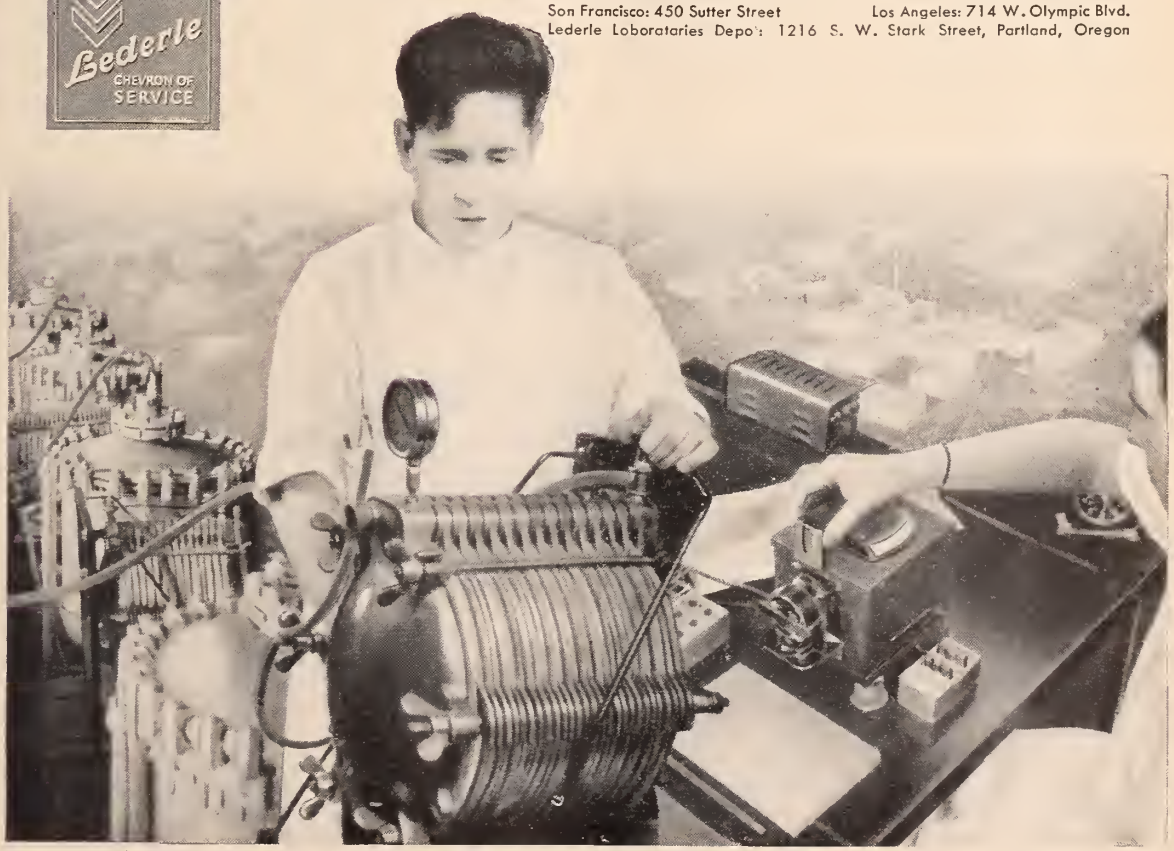

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(Continued from Page 34)

peared in the *Prager medizinische Wochenschrift* (14:33-35, 45-49, 1889). After describing his own case and adducing evidence that the diagnoses of osteomalacia made in earlier reported cases of albumosuria were incorrect, he says:

"In the above review, I believe I have done no violence to the facts, and accordingly feel justified in raising the question whether there was not in both these previous cases of marked albumosuria a multiple primary lymphosarcoma of the bone marrow exactly as in our case.

If I further venture with at least some degree of probability to answer this question in the affirmative, I may justifiably designate the marked albumosuria, which was noted in three similar cases, a frequently encountered symptom of this disease of the bone marrow.—R. W. B., in *New England Journal of Medicine.*

Definition of the Word "Biopsy" Is Given.—"Language is constantly changing," *The Journal of the American Medical Association* says. "The sense of a word in common usage may diverge so far from the dictionary definition that redefinition may be required.

"Consider the word 'biopsy.' The dictionaries agree essentially in defining biopsy as the examination for purposes of diagnosis of a portion of tissue removed from the living body. Usage, however, seems to make 'biopsy' mean the process of removing the living tissue rather than the examination. If the dictionaries are followed, the pro-

(Continued on Page 38)

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(Continued from Page 36)

cedure of removal is described in such a roundabout manner as 'removal of lymph node for biopsy.' If common usage is followed and the word is employed to refer to the procedure of removal only, the examination is awkwardly described as 'examination of tissue removed by biopsy.' Etymologically the term 'biopsy' must be compared with the words 'necropsy' or 'autopsy,' which mean examination of the dead body; the dictionary definition is correct etymologically in restricting the definition to the examination. Practically, however, the removal of tissue and its examination are integral parts of the same procedure; ordinarily the entire process, including both removal and examination, is meant when the word 'biopsy' is employed.

"The following working definition will be followed in the future in the use of the word 'biopsy' in publications of the American Medical Association: 'The removal and examination of a piece of tissue from the living body for purposes of diagnosis (usually microscopic).' For example, the phrase 'biopsy of lymph node' will mean the procedure of removal and examination, and 'the biopsy showed . . .' will refer to the results of the examination as part of the whole procedure."

Dr. or M. D.?—With every gymnast, music teacher, philosopher, and cultist calling himself "Doctor," it is no wonder that the public is becoming increasingly confused. Not only do correspondence school alumni with a yen for ornamentation use the "Doctor" label, but many respectable citizens, like dentists and clergymen, have a legiti-

(Continued on Page 40)

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(1) 1935. J. Home Econ. 27, 658.
(2) 1931. Ind. Eng. Chem. 23, 1066.

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(Continued from Page 38)

mate claim to the title, too. It seems that the physician's best way of clearing out the fog is to exhibit the distinguishing "M. D." on his sign, letterhead, prescription blank and phone book. Eventually it will bite into public consciousness. In fact, it is even possible to stress "M. D." in speech. Thus, we ask a patient: "Were these eyeglasses prescribed by a physician?" He answers yes because he thinks that the optometrist is an "eye physician," but were we to ask if the glasses were prescribed by an M. D., the patient would get the point promptly.

While physicians may resent the growing dilution of the title "doctor," let it be remembered that the label was never our exclusive property anyway. On the other hand, "M.D.," that unmistakable touchstone of the doctor of medicine, is the insignia of a hard-earned professional status. It is a good point to remember for the next order for check books or stationery.—*Journal of the Medical Society of New Jersey.*

Find Syphilis Rate of 4.52 Per Cent Among First Million Selectees.—"A rate of 45.2 cases of syphilis per thousand persons examined was found through physical examinations and routine serologic blood tests of the first million selectees and volunteers called for classification under the Selective Service Act of 1940," R. A. Vonderlehr, M. D., and Lida J. Usilton, M. A., Washington, D. C., report in *The Journal of the American Medical Association.*

"The greatest prevalence of syphilis among the selectees and volunteers was reported by Florida and South Carolina, with rates of 170.1 and 156 cases per thousand respectively," they say. "The lowest rate, of 5.8 per thousand, was reported by New Hampshire. Seven Southern states and the District of Columbia reported rates in excess of one hundred cases per thousand. The rate for Negroes is consistently higher than that for white men in all the states. There are indications that high rates among the white are coincidental with high rates among the Negroes. For the country as a whole, the prevalence of syphilis among Negro selectees and volunteers is thirteen times that for the white. In twenty states and the District of Columbia the Negro rate is in excess of ten times that of the white rate."

Say Outlook for Coronary Thrombosis Is Generally Quite Favorable.—A ten-year analysis of the after-history of two hundred patients with coronary thrombosis (obstruction by blood-clots of the arteries supplying blood to the heart muscle) indicates a favorable outcome in a larger percentage of cases than is generally appreciated, Doctors Edward F. Bland and Paul D. White of Boston report in *The Journal of the American Medical Association* for October 4. The two men point out that although particularly encouraging reports of special instances of an unusual longevity of seventeen to thirty-seven years have been made occasionally, the implication for the majority of patients with coronary thrombosis has been still far from comforting. They report on the history of two hundred patients seen by them between 1920 and 1930.

"Of the entire series," they say, "thirty-eight (19 per cent) died during the first four weeks after their initial attack. . . . Approximately one-third (34 per cent) of the 162 patients who survived the acute attack recovered completely, in that they were able to carry on without cardiac [heart] symptoms. . . . The course of this group was the most favorable; more than half (56 per cent) survived the first decade. Of those who died after temporary 'complete' recovery, coronary insufficiency accounted for most of the deaths. . . . Of the eighteen patients who

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succumbed to failure of the coronary circulation, eleven had another and fatal occlusion [blocking]; six died suddenly, presumably of acute coronary insufficiency . . . and one died during severe angina pectoris [heart pang]. It is of interest that only one in the group who completely recovered later had congestive failure.

"In contrast to the group who completely recovered, a second group of sixty-three . . . were limited thereafter by angina pectoris on effort. Nevertheless, nineteen survived the ten-year period. A slightly higher proportion (thirty-four to forty-four patients, or 77 per cent) died later of coronary insufficiency. . . . Of these thirty-four, eleven had a subsequent fatal occlusion, fourteen died of increasingly severe angina pectoris, and nine died suddenly. Again it is of interest that only two later had progressive congestive failure.

"Finally, among the remaining forty-four patients, dyspnea [labored breathing] on exertion . . . was chiefly responsible for limitation of activity, although some had both angina pectoris and dyspnea. . . . None with dyspnea survived the ten-year period. . . .

"Thirty-three of the fifty patients who survived the first decade were limited by angina pectoris as they entered the second decade, and nine of these had one or more later attacks of coronary thrombosis; the remaining seventeen were without cardiac symptoms, although six had further attacks of coronary thrombosis, from which they completely recovered."

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1937

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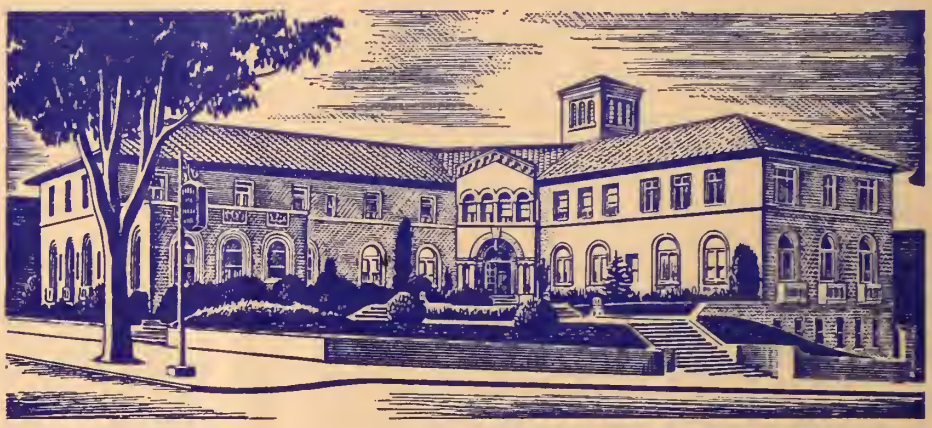

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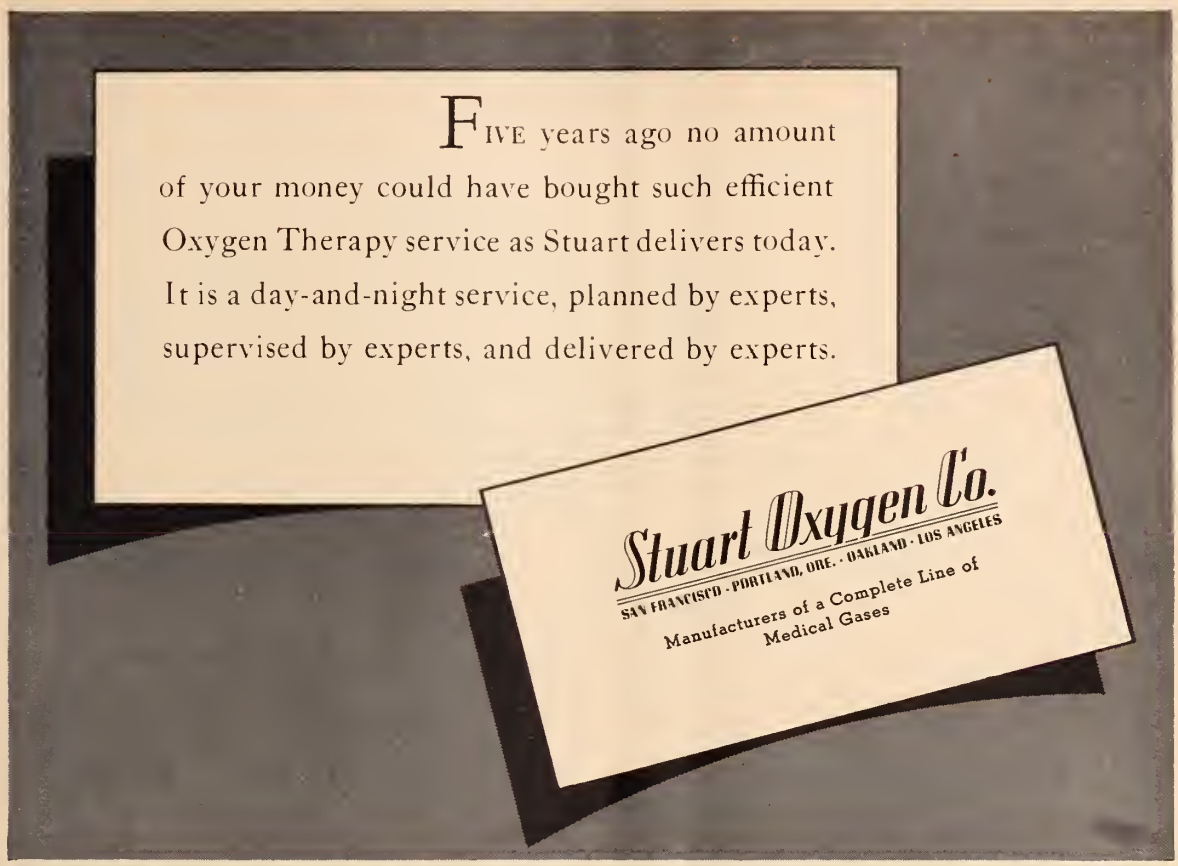

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Secretary, L. Henry Garland, 2180 Washington Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society

President, Raymond Leroy Owens, 28 Cory Building, Lodi.
Secretary, George H. Rohrbacher, 1005 Medico-Dental Building, Stockton
Acting Secretary, C. A. Broaddus, 242 North Sutter Street, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society

President, Horace Hagan, 1215 Chorro Street, San Luis Obispo.
Secretary, E. M. Bingham, County Health Department, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society

President, H. H. Whitney, 1204 Burlingame Avenue, Burlingame.
Secretary, Thomas Farthing, 23 Second Avenue, San Mateo.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society

President, H. R. Schwalenberg, Cottage Hospital, Santa Barbara.
Secretary, Alfred B. Wilcox, 1515 State Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society

President, A. J. Baiocchi, 369 South Third Street, San Jose.
Secretary, Leon P. Fox, Ste. Claire Building, San Jose.
Meeting, *Third Monday, 7:00 p. m., Sainte Claire Hotel, San Jose.*

Santa Cruz County Medical Society

President, Avery Wood, 335 Main Street, Watsonville.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meeting, *First Tuesday of each month (except June, July and August), 7:30 p. m., Club Rio del Mar, Aptos.*

Shasta County Medical Society

President, Earnest Dozier, Redding.
Secretary, Julius M. Kehoe, Redding.
Meeting, *Second Monday.*

Siskiyou County Medical Society

President, F. W. Martin, 106 Orem Street, Mt. Shasta.
Secretary, Victor W. Hart, 113 No. Oregon Street, Yreka.
Meeting, *Sunday on call.*

Solano County Medical Society

President, Gordon Bunney, Suisun.
Secretary, F. Burton Jones, 416 Georgia Street, Vallejo.
Meeting, *Second Tuesday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society

President, Leighton Ray, 536 B Street, Santa Rosa.
Secretary, John O. Raffety, 505 B Street, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society

President, Hoyt R. Gant, 1024 J Street, Modesto.
Secretary, A. E. Ghilotti, 1024 J Street, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society

President, R. G. Frey, Red Bluff.
Secretary, F. J. Bailey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society

President, Ray E. Cronemiller, 160 South E Street, Exeter.
Secretary, Forrest G. Powell, 222 W. Willow Street, Visalia.
Meeting, *Sunday Evening once a month*

Ventura County Medical Society

President, James W. Moore, 23 S. California Street, Ventura.
Secretary, Robert K. Harker, 132 Fourth Street, Oxnard.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society

President, Edwin K. Copeland, 405 First Street, Woodland.
Secretary, Wilfred T. Robbins, 719 Second Street, Davis.
Meeting, *First Wednesday.*

Yuba-Sutter-Colusa County Medical Society

President, Romayne B. Whitney, Plumas Street, Yuba City.
Secretary, Leon M. Swift, I. O. O. F. Building, Marysville.
Meeting, *Second Wednesday.*

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1. Knight, F., and Shelanski, H. A., "Treatment of Acute Anterior Urethritis with Silver Picrate," Am. J. Syph., Gon. & Ven. Dis., **23**, 201 (March), 1939.

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(Continued from Page 3)

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In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the libraries of the following institutions:

University of California Medical Library, Medical Center, San Francisco.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco.

Barlow Medical Library (Los Angeles County Medical Association), 634 South Westlake, Los Angeles.

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Miscellaneous California Medical Organizations

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Sacramento—State Office Building, Tenth and L streets, CApital 2800.
Los Angeles—State Office Building, 217 West First Street. MAdison 1281.
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California Northern District Medical Society

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Board of Medical Examiners of the State of California

San Francisco, Rm. 214, 515 Van Ness Ave.
Los Angeles, 906 State Building.
Sacramento, Business and Professional Bldg., 1020 N Street.
President, Clark L. Ahhott, Oakland.
Secretary, C. B. Pinkham, Room 214, 515 Van Ness Avenue, San Francisco.

Southern California Medical Association

President, Alvin Foord, 749 Fairmont Ave., Pasadena.
Secretary, Edward W. Boland, 2202 W. Third Street, Los Angeles.

The Public Health League of California

Executive Secretary, Ben H. Read, San Francisco office, 244 Kearny Street, phone SUtter 8470. Los Angeles office, Room 563, 1151 South Broadway, phone PRospect 5711.

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BOOK REVIEWS

BOOKS RECEIVED

William Henry Welch and the Heroic Age of American Medicine. By Simon Flexner and James Thomas Flexner. Cloth. Price, $3.75. Pp. 539, with 26 illustrations. New York: The Viking Press, 1941.

Functional Pathology. By Leopold Lichtwitz, M. D., Chief of the Medical Division of the Montefiore Hospital; Clinical Professor of Medicine, Columbia University, New York. Cloth. Price, $8.75. Pp. 567, with 198 pictures, plates, photographs, charts, and tables. New York: Grune & Stratton, Incorporated, 1941.

Shock Treatment in Psychiatry: A Manual. By Lucie Jessner, M. D., Ph. D., Resident Psychiatrist, Baldpate, Georgetown, Massachusetts; Graduate Assistant in Psychiatry, Massachusetts General Hospital; Assistant in Psychiatry, Beth Israel Hospital, Boston, and V. Gerald Ryan, M. D., Associate Psychiatrist, Elmcrest Manor, Portland, Connecticut; Assistant in Psychiatry, Harvard Medical School. Introduction by Harry C. Solomon, M. D., Clinical Professor of Psychiatry, Harvard Medical School; Chief of Therapeutic Research, Boston Psychopathic Hospital. Cloth. Price, $3.50. Pp. 149. New York: Grune & Stratton, Incorporated, 1941.

Infant Nutrition: A Textbook of Infant Feeding for Students and Practitioners of Medicine. By William McKim Marriott, B. S., M. D., Late Professor of Pediatrics, Washington University School of Medicine; Physician in Chief, St. Louis Children's Hospital, St. Louis. Revised by P. C. Jeans, A. B., M. D., Professor of Pediatrics, College of

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Medicine, State University of Iowa, Iowa City. Third edition. Cloth. Pp. 475, with 16 illustrations. St. Louis: The C. V. Mosby Company, 1941.

Rheumatic Fever in New Haven. Edited by John R. Paul, M. D., Professor of Preventive Medicine, Yale University School of Medicine. Paper. Price, $1. Pp. 176. Lancaster, Pennsylvania: The Science Press Printing Company, 1941.

The Treatment of Infantile Paralysis in the Acute Stage. By Elizabeth Kenny. Cloth. Pp. 285, with 66 illustrations. Minneapolis: St. Paul: Bruce Publishing Company, 1941.

Symptoms in Diagnosis. By Jonathan Campbell Meakins, M. D., LL. D., Professor of Medicine and Director of the Department of Medicine, McGill University; Physician-in-Chief, Royal Victoria Hospital, Montreal; Formerly Professor of Therapeutics and Clinical Medicine, University of Edinburgh; Fellow of the Royal Society of Edinburgh; Fellow of the Royal Society of Canada; Fellow of the Royal College of Physicians, London; Fellow of the Royal College of Physicians, Edinburgh; Honorary Fellow of the Royal College of Surgeons, Edinburgh; Fellow of the Royal College of Physicians, Canada; Fellow of the American College of Physicians. Cloth. Price, $4. Pp. 323. Boston: Little, Brown & Company, 1941.

Preëclamptic and Eclamptic Toxemia of Pregnancy. By Lewis Dexter, A. B., M. D., Research Fellow in Medicine, Harvard Medical School, and Soma Weiss, A. B., M. D., Hersey Professor of the Theory and Practice of Physic, Harvard University; Physician-in-Chief, Peter Bent Brigham Hospital, in collaboration with Florence W. Haynes, Herbert S. Sise, and James V. Warren. Cloth. Pp. 415. Boston: Little, Brown & Company, 1941.

Diseases of Women. By Harry Sturgeon Crossen, M. D., F. A. C. S., Professor Emeritus of Clinical Gynecology,

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(Continued from Preceding Page)

Washington University School of Medicine; Gynecologist to the Barnes Hospital, St. Louis Maternity Hospital, and St. Luke's Hospital; Consulting Gynecologist to De Paul Hospital and the Jewish Hospital; Fellow of the American Gynecological Society and of the Central Association of Obstetricians and Gynecologists, and Robert James Crossen, A. B., M. D., Assistant Professor of Clinical Gynecology and Obstetrics, Washington University School of Medicine; Assistant Gynecologist and Obstetrician to the Barnes Hospital and the St. Louis Maternity Hospital; Assistant Gynecologist to the St. Louis Children's Hospital; Gynecologist and Obstetrician to St. Luke's Hospital and to De Paul Hospital; Fellow of the Central Association of Obstetricians and Gynecologists; Diplomate of American Board of Obstetrics and Gynecology. Cloth. Pp. 948, with 1127 engravings, including 45 in color. St. Louis: The C. V. Mosby Company, 1941.

Diseases of the Blood and Atlas of Hematology, with Clinical and Hematologic Descriptions of the Blood Diseases, Including a Section on Technic and Terminology. By Roy R. Kracke, M. D., Professor of Bacteriology, Pathology and Laboratory Diagnosis, Emory University School of Medicine. Pathologist to the Emory University Hospital. Consultant in Hematology to the Grady Hospital and Eggleston Hospital for Children, Atlanta, Georgia. Formerly Director of the Hematological Registry, American Society of Clinical Pathologists. Cloth. Pp. 692, including 54 color plates and 46 other illustrations. Philadelphia: London: Montreal: J. B. Lippincott Company. 1941.

The Retina: The Anatomy and the Histology of the Retina in Man, Ape, and Monkey, Including the Consideration of Visual Functions, the History of Physiological Optics, and the Histological Laboratory Technique. By S. L. Polyak, M. D. Cloth. Price, $10. Pp. 721. Chicago: The University of Chicago Press, 1941.

(Continued on Page 12)

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BOOKS RECEIVED

(Continued from Page 10)

Annual Report of the Board of Regents of the Smithsonian Institution: Showing the Operations, Expenditures, and Conditions of the Institution for the Year Ended June 30, 1940. Cloth. Price, $1.50. Pp. 512, with 165 illustrations. Washington: United States Government Printing Office, 1941.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 336)

Sad But True.—Many times during the last eight years has this *Journal* commented on the fact that the careless utterances of physicians very frequently resulted in damage suits. Occasionally, too, we have referred to the fact that a physician, without knowing all the circumstances and conditions of a case, will express an emphatic opinion. Somehow or other physicians, though their whole lives are spent in contact with patients, cannot seem to realize that nothing is so unreliable as a patient's statement of what some other doctor did. There is nothing more dangerous than one can readily think of than accepting the opinion

(Continued on Page 14)

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TWENTY-FIVE YEARS AGO

(Continued from Page 12)

of the patient or layman as to the condition of the patient, or what other doctors have done in the way of previous treatment or operations. . . .

EXCERPTS FROM MISCELLANEOUS ARTICLES

From an Article on "Principles and Problems of Industrial Accident Work," by Morton R. Gibbons, M. D., San Francisco.—I am asked to speak on the principles and problems of Industrial Accident Work. This subject, I know, should be treated from the doctor's side. However, the doctor's side and the Commission's side are so dovetailed as to be almost indistinguishable.

It is the duty of the Industrial Accident Commission to administer a law which at once requires consideration of medical subjects, legal subjects, moral subjects, and general humanitarianism.

The text of the law says: "Neither Commission, nor referee appointed thereby, shall be governed by the technical rules of evidence." I suspect that many doctors who have come in contact with the law have gathered the idea that the Commission applies this privilege to medical as well as to legal subjects.

The Commission had at the outset a difficult duty to perform. There were few Commissions in this country when our law became effective. The laws in existence had less scope than has the California law. No Commission had gone far; all were pioneering. The foreign laws help little because of differences of the basic principles of our Government. Our Commission had to make all its rules of procedure and establish its own precedents. . . .

(Continued on Page 16)

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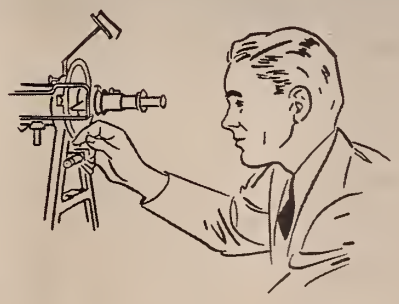

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CALSO WATER is not a laxative.

TWENTY-FIVE YEARS AGO

(Continued from Page 14)

From an Article on "Streptococcic Infections of the Skin," by Ernest Dwight Chipman, M. D., San Francisco. Just as in surgical practice the streptococcus is seen to infiltrate subcutaneous tissues and spread rapidly while the activities of the staphylococcus are held in check by defensive abscess walls, so in dermatologic practice the streptococcus, invading the epidermis, shows a marked tendency to rapid dissemination as compared with the staphylococcus, which is more strictly confined in its activities to the pilosebaceous orifices.

From an Article on "Fibromyoma Uteri: Sketch of Treatment, Operative and Otherwise, with Special Reference to Roentgen-Ray Therapy," by Henry J. Kreutzmann, M. D., San Francisco.—In the following sketch, I shall attempt to describe to you the development of the treatment of fibromyoma uteri (f. m. u.), basing my remarks mostly on personal observation during my professional career, extending now over thirty-six years of active work.

I had the good fortune to be assistant to the Chair of Obstetrics and Gynecology at the University of Erlangen under Prof. Zweifel in 1880-81. This was a glorious period of medical history; under the protection of antiseptic measures, new undreamed of operations were thought out and carried out successfully, especially abdominal operations. Zweifel was a moving spirit; everything newly published was tried, original ideas put to work. The f. m. u. that came to operation were all of large, sometimes enormous size; these women were all suffering severely, life frequently was a burden; the indication for operation was a vital one. The operation of these tumors

(Continued on Page 18)

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● *The name is never abbreviated; and the product is not like any other infant food—notwithstanding a confusing similarity of names.*

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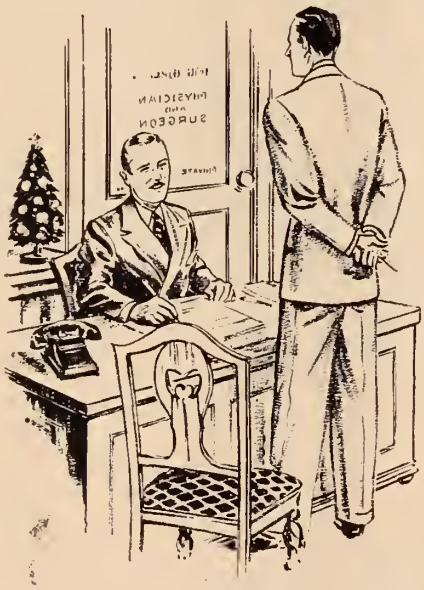

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TWENTY-FIVE YEARS AGO

(Continued from Page 16)

consisted in ligating the uterine adnexa, putting some ligature around the lower segment of the mass, amputation, extraperitoneal fixation of the stump in the lower angle of the abdominal incision. . . .

From an Article on "Incipient Systemic Disturbances as Shown by Ocular Signs," by E. W. Alexander, M. D., San Francisco.—The diagnosis and prognosis of many systemic conditions have become so intimately connected with the signs and symptoms of ocular origin that proficiency in the use of the ophthalmoscope will become universal among internists in a few years.

The significance of an albuminuric retinitis, disseminated choroiditis, Argyll-Robertson pupil, or papillo-edema is now instantly appreciated even by the typro of internal medicine.

Still further, as illustrative of more specialized signs, we find a beginning temporal atrophy to be suggestive of an early multiple sclerosis; transient attacks of diplopia, of tabes; hemorrhages in the retina, of apoplexy, etc.

But what needs to be emphasized is the correlation of eye signs and the finer balance of the organism as a whole: the signs indicative of disturbed vasomotor and trophic nerve functions, of errors of metabolism, and of hygiene. . . .

From an Article on "Salvarsan and Neosalvarsan in Tropical Diseases," by Herbert Gunn, M. D., San Francisco.—The following article is a review of the literature to which a few personal observations have been added. Since the advent of these drugs they have been employed

(Continued on Page 20)

The Sickle Has Lost Its Edge

SLOWLY BUT SURELY, MEDICAL SCIENCE IS CONQUERING SYPHILIS

Mapharsen offers a record for effectiveness and safety as an antiluetic which has not been surpassed by any other arsenical since the days of Ehrlich. The proof lies in the more than ten million intravenous injections administered over a seven year period.

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130 STORES ON THE PACIFIC COAST

TWENTY-FIVE YEARS AGO

(Continued from Page 18)

extensively in tropical diseases and in some with beneficial effect.

Moloria: In this disease salvarsan seems to produce the greatest effect on the benign tertian parasite which is the most amenable to quinin treatment. . . .

From an Article on "Supplementary Report of Human Cases of Rabies in California," by J. C. Geiger, M. D., Berkeley.—In a previous article, the number of cases of rabies in human beings in California was reported as thirty-four. A report of two additional cases, making thirty-six in all, is given, as follows: . . .

From an Article on "Recent Work in Epilepsy," by Edward W. Twitchell, M. D., Sacramento.—Epilepsy has so long been one of the opprobria medicorum that we welcome anything new of promise, either in respect of cause or of treatment, even if the promise be a bit vague. I have endeavored to put together the results of a search of the literature of the subject covering the last three or four years.

The methods of research are so largely biochemical and bacteriological that they present a striking contrast to the methods of not so many years ago when the histological method was almost the exclusive one. . . .

From an Article on "Roentgen Treatment of Localized Pyogenic Infections, with Report of Eight Cases," by Howard E. Ruggles, M. D., San Francisco.—In view of the remarkable results of roentgen therapy in cases of

(Continued on Page 22)

Pledge for 1942

THIS month, as we see the last page of the old calendar about to come down, to be replaced by a new one we pause to express gratitude on the one hand, hope on the other. Gratitude that we have been privileged, through the patronage of our friends, to share with them responsibility for the preservation and care of health and vision—hope that the new year will find us able to serve in this great work with even greater efficiency.

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TWENTY-FIVE YEARS AGO

(Continued from Page 20)

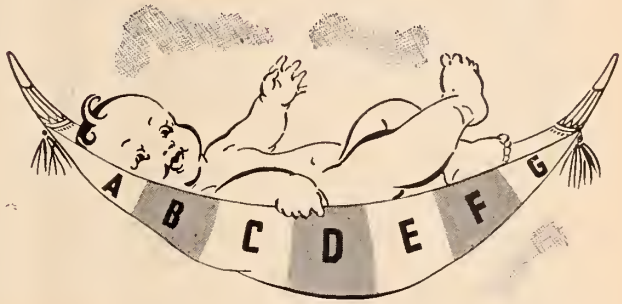
tuberculous cervical adenitis, the question has arisen as to what effect would be produced by similar treatment of localized pyogenic infections. . . .

From Item: Status and Standards of Dispensary Practice.—It is admittedly true that in the development of the present-day hospital system the growth in size and departments of the out-patient departments has been faster than their growth in efficient methods of practice and administration. There is no doubt that the out-patient department and dispensary have come to stay and that the growing demand for their services will lead to still greater development and extension in the near future. There is reason for believing that the dispensary will come to be one of the chief agents in public health and preventive medicine propaganda. It has been recognized, of course, as a feeder for the hospital. But equally or even more important is its function in following up posthospital cases, both for treatment and for data on end-results. A specialized feature of dispensary practice is its application to preventive medicine. This is exemplified in the infants' milk stations and children's clinics, the tuberculosis clinics, and the social service features which are coming into increasing prominence. The dispensary system is being utilized to good advantage, too, by industrial concerns, both for treatment and for prevention. . . .

From Item: Report of the November Meeting of the State Board of Health.—The regular meeting of the State Board of Health was held in Sacramento on November 4.

(Continued on Page 24)

Baby "takes it Easy"



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A worthy vehicle for easy traveling through infancy, doctor. Shall we send you complete information about Baker's?

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A mixture of maltose and dextrins prepared by enzyme hydrolysis of cereal starch. (An easily assimilated carbohydrate, for the modification of fresh, evaporated and powdered cows' milk for infant feeding.) MELODEX is easily digested and readily absorbed. It permits a wide range of flexibility in the modification of cows' milk, and may be given in liberal amounts without producing intestinal disturbances in normal babies. Valuable for increasing the caloric content and improving the flavor of fresh whole milk for undernourished children, nursing mothers and convalescents. Very economical.

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TWENTY-FIVE YEARS AGO

(Continued from Page 22)

1916. There were present Doctors George E. Ebright, F. F. Gundrum, Edward F. Glaser, Robert A. Peers, and W. A. Sawyer. . . .

. . . In accordance with the recommendation of the Director of the Bureau of Sanitary Engineering, a permit was granted to the city of Chino to dispose of its sewage by irrigation, and a temporary permit was given to the city of Los Angeles to dispose of its untreated sewage into the ocean, pending the results of the proposed bond election for the installation of Imhoff tanks. A temporary permit was given to the city of Hanford to continue to dispose of sewage on its sewer farm.

The plans of the proposed Los Angeles Tuberculosis Hospital were discussed. The floor plan and the modified plan for the roof and the drainage system of the grounds were approved. The Board held that certain expenditures were not justified, as they could better be made for increasing the bed capacity. . . .

From Item: Navy Surgeons—

I am forwarding herewith for your information circulars describing the Medical Corps of the United States Navy.

Legislation has recently been enacted (in 1916) which will provide for approximately 300 additional medical officers in the Medical Corps of the United States Navy. . . .

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(Continued in Back Advertising Section, Page 28)

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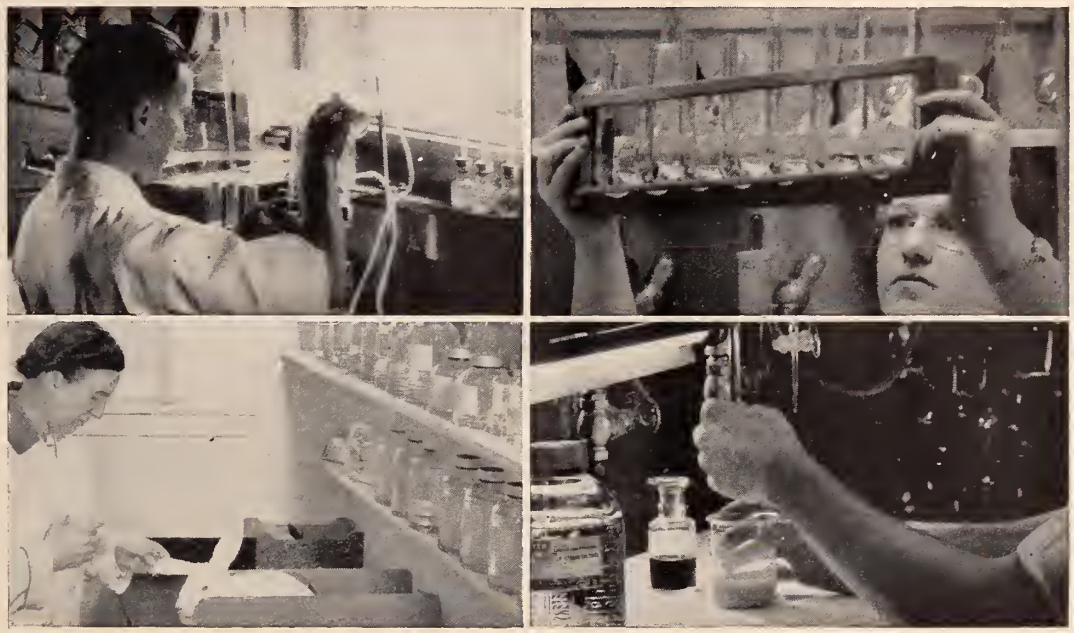

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CALIFORNIA AND WESTERN MEDICINE

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EDITOR . . . . . GEORGE H. KRESS

Committee on Publications

Francis E. Toomey.....San Diego 1942
G. W. Walker.....Fresno 1943
A. A. Alexander, Chairman.....Oakland 1944
Secretary-Editor, ex officio

Editorial Board

Roster of Editorial Board appears in this issue at beginning of California Medical Association department. (For page number see index below.)

Advertisements.—The Journal is published on the seventh of the month. Advertising copy must be received not later than the fifteenth of the month preceding issue. Advertising rates will be sent on request.

BUSINESS MANAGER . . . . . JOHN HUNTON

Advertising Representative for Northern California
L. J. FLYNN, 544 Market Street, San Francisco (DOuglas 0577)

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Change of Address.—Request for change of address should give both the old and the new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

WAR

War has come to our country. Japan's declaration against the United States and Great Britain, made on December 7, was announced as this issue of CALIFORNIA AND WESTERN MEDICINE is in press. From this time on, the rôle of Medical Preparedness takes on a different aspect.

The armed services must now be implemented to full strength in all branches. The Medical Corps of both Navy and Army require physicians to permit them to function in highest efficiency.

As in World War I, this need will be fully met by the medical profession. Organized and Scientific Medicine will give of their best. The California Medical Association gladly accepts its responsibilities.

THE SEASON'S GREETINGS

A Year of Trial.—Another year is nearing its end, during which, in the last twelve months, many members of the medical profession have found it necessary to make numerous and varied adjustments, some of a nature involving real hardships respecting their careers, and also to their families. To colleagues who have thus taken up new duties in these uncertain times, good wishes in generous amount are extended, and the hope expressed that, for them and theirs all may turn out for the best!

To other members of the California Medical Association, greetings of similar nature are given. Physicians not in military service are likewise faced with new conditions, the Nation's economic and other programs—brought about through the present international emergency—being still too much in a state of flux to permit citizens to foresee all that days to come may have in store.

Should the present crises be but forerunners of even graver events, physicians will probably be called upon to make greater sacrifices. However, if such be the course of affairs, then, as in the past, members of the California Medical Association will be found doing their part in full.

Therefore, in that knowledge and spirit of generous service to country and fellow-men, character-

† Editorials on subjects of scientific and editorial interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

istic of the medical profession, the coming year may be faced in hopeful confidence. And in this last month of the dying year, CALIFORNIA AND WESTERN MEDICINE extends to all its heartiest greetings of the holiday season.

NEXT ANNUAL SESSION: MAY 4-7, 1942

A Four- to Five-Day Session.—Six months have elapsed since the last annual session was held at Del Monte where, next year, the California Medical Association will again convene, beginning its work officially on Monday, May 4, and carrying on through Thursday, the 7th. In the contemplated arrangements, affiliated activities—such as the Microscopic, Radiologic, and Clinical Cancer Study Groups, the Heart Association and Industrial Medicine Symposia, and California Physicians' Service, will hold meetings on Sunday, May 3, in order to avoid conflicts that might impair the efficiency of the twelve Scientific Sections, whose programs make up practically the annual Scientific Assembly of the California Medical Association.

The forthcoming annual conference is called to the attention of members in the hope that many may make note of the time and place of meeting, and so give thought to possible attendance.

Such a reminder is of equal importance, also, to prospective essayists or program participants, since any who have not communicated with the proper Section Secretaries (whose names will be found on advertising page 4), should promptly do so.

* * *

Program Committee Holds Meeting.—On Sunday, November 23, the State Association Committee on Scientific Work met in joint session with the Section Secretaries, when progress reports were submitted and plans outlined through which, it is hoped, the meetings of the various sections will take on increased interest and value.

The general scheme of time allocations, inaugurated several years ago, has been found satisfactory.

The plan, then instituted, provides for four general sessions, one of which shall be held each morning, when programs of special value to Association members who are in general practice are given. Major topics for the four mornings, which will be emphasized, are: Monday, Organized Medicine; Tuesday, Internal Medicine and Clinico-Pathologic Conference; Wednesday, Surgery; Thursday, Progress Reports on Newer Methods in Practice.

Each morning, medical and surgical films will be displayed in one of the meeting rooms; and on each afternoon, the twelve Scientific Sections will present their special programs. The scientific and technical exhibits will be on display throughout the entire day.

* * *

Meeting Room Pavilion Under Construction. Section members who in the past have been distressed at the crowding and inconveniences associated with meeting rooms of insufficient size will be happy to learn that the new assembly pavilion at Hotel Del Monte, now under construction, will provide six additional meeting rooms. These accommodations will also make for better lobby features, thus promoting the good fellowship and fraternal features of the annual convention, always so desired. The enlarged meeting room space will also permit the Woman's Auxiliary to hold its meetings at the Hotel Del Monte, instead of at the Lodge—a convenience long wished for.

At the meeting on November 23, referred to, it was agreed that at the coming annual session, panel and round-table discussions should be promoted, although symposia and individual papers will also continue to be presented.

* * *

Prospective Participants Must Send Requests. In due course, additional information concerning these matters will appear in CALIFORNIA AND WESTERN MEDICINE. In the meantime, as already noted, all members who have in mind the submittal of topics for program placements should promptly communicate with the proper Section Secretary.

* * *

Scientific Exhibits: How the Medical Schools Can Aid.—Members in position to present scientific exhibits or medical films should write to the Association Secretary. In connection with scientific exhibits, special appeal for coöperation is made to the four medical schools of California, since each has facilities easily permitting the presentation of exhibits of pathologic and research material. By so doing, a return courtesy would be extended to the California Medical Association for the aid so consistently given by it in antivivisection and similar battles. The California Medical Association takes pride in the State's four medical schools; and they, in turn, should be happy to promote the postgraduate phases of the Association's annual sessions, the important work the yearly gatherings are intended to promote.

MEDICAL PREPAREDNESS: RECENT PROBLEMS

California Committee on Medical Preparedness.—CALIFORNIA AND WESTERN MEDICINE, in its issue of August, 1940, called attention to the newly organized California Committee on Medical Preparedness—consisting of state and county committees—and in each subsequent issue progress reports have appeared. The present international outlook indicates that, for some time to come, Medical Preparedness must continue as a standing department of the OFFICIAL JOURNAL, due in part to rapid changes in the new military alignments affecting physicians, and also to confusions that have arisen through difficult interpretation of the somewhat inelastic features of the Selective Service Act and Army regulations.

* * *

Recent Meeting at American Medical Association Headquarters.—At the annual meeting of State Association secretaries and editors, held at the American Medical Association headquarters in Chicago, on November 14-15, officers of the military services discussed some of the problems relating to the Medical Corps. The questions asked by representatives from different states of the

Union indicated that doubts on procedure were not limited to any particular area, but were in evidence almost everywhere. Many physicians in active practice hold Medical Reserve Commissions, and, because of such rank, they may at any time be notified to present themselves for induction into active service. Therefore, the subject is always pertinent and of particular interest to the medical profession.

The serious aspects of changes in medical service for the civilian population, through withdrawal from practice of medical reserve officers, is enhanced by the fact that the system and standards of present-day medical schools provide for a yearly addition of about 5,200 graduates, a number deemed necessary for replacements in times of peace.

Medical practice stress and strain come into operation, however, when some thousands of younger physicians are taken from civilian practice, and when also a large proportion of the medical graduates of each year may be called into military service. Supplementary to these interferences with past needs and procedures, other problems, dependent on inadequacies not foreseen or difficult to prevent, can come into being.

* * *

Never-Ending Problems.—When groups of medical men gather together, these newer problems and responsibilities are often discussed, and it is not unusual to hear the recital of special cases, with involved hardships, difficult to explain. Probably, as time moves on, and experience increases, it may become possible to clarify some of the situations which have arisen. For instance, it is difficult to explain to physicians who have had many years of large experience why, as officers in the Medical Reserve, they cannot hope to secure a higher rank and pay than that of Major in the Army, and that, too, no matter how great their qualifications.

Certainly, for some colleagues who, themselves past the draftee age, have been obliged to give up large practices for possibly indeterminate periods, with no provisions for retirement pay, etc., and also the chance of being obliged some time in the remote future to again try to build up practices sufficient to care for family needs and other responsibilities, the future does not take on a very roseate hue. For such reasons, state and county medical organizations should exempt those in military service from payment of dues, and their members should make real efforts to conserve both hospital and practice affiliations of military colleagues, in so far as may be possible.

* * *

Medical Schools and Medical Students.—The Selective Service Act grants to local boards sole authority concerning deferments. The office of the Surgeon General has promulgated rules through which it is hoped an ample supply of well-trained younger physicians may be brought into service. It is important that the deans of the medical schools should place on their bulletin boards, and in the hands of all medical students, an outline of the procedures and responsibilities involved through service in either the Medical Administrative Corps or the Medical Reserve. Through misunderstanding or noncompliance with existing provisions and procedures, it may happen that some medical graduates will find themselves, later on, in military service as line soldiers, instead of officers with commissions in the Medical Reserve.

Thought may also be given to proper physical examination of medical matriculants, so that practically all medical students will possess physical fitness for military service. Otherwise, such physically deferred graduates may promptly be inducted into civilian practice, upon graduation, to the detriment of fellow graduates and older physicians who would be obliged to remain in military service, finding, on coming out to again take up civilian work, such deferred graduates opposing them in well-established practices.

At the Chicago conference, these and related subjects were discussed by General Lewis Hershey, whose paper may appear in the *Journal of the American Medical Association* before this issue of California and Western Medicine comes from the press.*

* * *

Rehabilitation Plans.—In last month's issue, considerable space was given to Rehabilitation Plans. It is now agreed that the group of selectees who offer the best opportunities for rehabilitation procedures that would make them available for military service are those with dental defects; and in the beginning, they will probably be the selectees for the first major rehabilitation group.

Other matters related to military service are receiving the attention of officers of the Association, and, should occasion arise, may be made the subject of later comment.

COUNTY SOCIETY WORK—FOR THE YEAR 1942

New Officers Accept New Responsibilities.—In many county societies, new officers, at the beginning of the calendar year, take up their duties in January. It is in order, therefore, to call attention to several State Association activities, in which the coöperation of component county units is necessary, if successful results are to be obtained. Among such may be mentioned: Postgraduate Conferences; Public Health Exhibits and Films at State and County Fairs; Organization Meetings; Historical Investigation. At this time, some brief comment concerning each.

* * *

Postgraduate Conferences.—Every county society—other than those in close proximity to metropolitan hospitals where access to ward walks and clinics is available—may well have a Postgraduate Committee. The names of its members and that of its chairman should be sent to the Association Secretary, who, as secretary of the California Medical Association Committee on Postgraduate Activities, will forward informative literature concerning courses, give aid in securing guest speakers, and also promote publicity concerning conferences,

* The points brought out by Brigadier-General Hershey are worthy of careful consideration and will be published in full in *The Journal of the American Medical Association* for November 29, under the heading of Medical Preparedness.

through circularization of the programs to members of sponsoring and adjacent county societies.

* * *

Value of State and County Fairs in Publicity Work.—No other agencies than County Fairs in California, which begin as early as February—save the State Fair—have such great potential resources for easy and successful publicity on matters of public health and the work of scientific medicine. For the development of this activity, likewise, almost every county unit should appoint a special committee. Through the Committee on Public Health Education, it is hoped to present excellent exhibits in 1942. For additional information, request should be made to the Association Secretary, Dr. George H. Kress, at 450 Sutter, San Francisco.

* * *

Organization Meetings.—The officers of the California Medical Association (President, President-Elect, Councilors and Association Secretary), have already started their yearly visits to component county societies. Because of the time involved in travel, it is sometimes necessary to ask component societies to hold meetings on other than regular dates, in order that two or three nearby societies may be visited on successive evenings. At such meetings, the whole or part of the session may be given over to a discussion of the work of organized medicine. If a guest speaker to take up a scientific topic is desired, effort will be made to procure one. Suggestions are invited.

* * *

Annual Reports of County Societies.—In this issue appear the annual reports of the component county units of the California Medical Association, and the attention of members is called to the outlines of work recorded.* Particularly, these letters should be read by the officers of county societies, since the activities enumerated may have suggestive value.

* * *

Histories of County Societies.—Each county medical society should have a Committee on History. The California Medical Association was founded almost one hundred years ago. Sad to confess, the records of its past are practically nil. In each county, the local Committee on History should gather together all available archives and also ask older members to write sketches of experiences in days gone by. If such articles are sent to the Association Secretary, copies will be typed for the California Medical Association and county society archives. A beginning will thus be made.

Coöperation by county societies in the activities above discussed is urgently requested.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 311.

* See page 316.

EDITORIAL COMMENT†

CONCOMITANT ANTIGENS IN VIRUS DISEASES

It is currently reported by Smadel and Wall,[1] of the Rockfeller Institute, that the complement-fixing antibody, viricidal antibody and essential fixed-tissue immunity are independent variable in animals infected with lymphocytic choriomeningitis. This conclusion tends to emphasize certain basic factors in antiviral immunity not yet incorporated in conventional clinical theory.

That antiviral immunity is a more complex physiological process than that thus far assumed for bacterial infections, has been well established for numerous virus diseases. It was shown by Hughes [2] and other investigators, for example, that in natural or experimental infections with yellow fever, a complement-fixing (or precipitable) factor is formed or liberated in the blood stream during the initial stages of the infection, the amount of which antibody varies roughly with the severity of the symptoms. This precipitinogen is not identical with the specific virus, and has no demonstrable therapeutic action against the infection. Hughes concluded that the substance is presumably a specifically denatured tissue albumin set free as a result of infectious injury.

This hypothetical denatured tissue protein is auto-antigenic, stimulating the production of a specific precipitin with a resultant disappearance of the circulating precipitinogen in later stages of the natural or experimental infection. Thus, the serum of recent convalescent human cases contains this anti-autogenous precipitin, flocculation reaction between the initial febrile and early convalescent serum being of diagnostic significance. Hughes suggested the application of this reaction as a reliable method of differential diagnosis during presumptive epidemics of yellow fever.

This convalescent precipitin in turn does not long persist in the circulating blood. In human cases, and in most monkeys thus far observed, it disappears quantitatively within a few months. The precipitin is apparently chemically independent from the viricidal antibody which may persist for years.

A somewhat similar series of concomitant immunochemical events was described by Wilson Smith [3] of the British National Institute for Medical Research. Smith found that, in testicular vaccine virus infections of rabbits, a specific precipitinogen could be extracted from the local tissues, capable of reacting with a specific precipitin in homologous convalescent rabbit serum. Howitt [4]

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† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

1 Smadel, J. E., and Wall, M. J.: Jour. Exper. Med., 72:389 (Oct.), 1940.

2 Hughes, T. P.: Jour. Immunol., 25:255, 1933.

3 Smith, Wilson: Brit. Jour. Exper. Path., 13:434, 1932.

4 Howitt, Beatrice F.: Jour. Immunol., 33:235, 1937.

afterward applied a similar technique to the differential diagnosis of equine encephalomyelitis, human encephalitis and lymphocytic choriomeningitis, using the more delicate complement-fixation reaction. Howitt tested extracts of the fixed tissues of virus-infected guinea pig and found highly specific factors that would react with homologous hyperimmune guinea-pig serum. The active component in such extracts readily passes through the pores of a medium fine gradocol membrane, and thus may be completely separated from the specific virus causing the disease.

Smadel [5] and his coworkers of the Rockefeller Institute have accomplished the same separation of the "soluble substance" from the accompanying virus by ultracentrifuge methods. In lymphocytic choriomeningitis infections, for example, the washed virus fixes complement poorly, while a high complement-fixing titer is shown by the soluble tissue component. This specific soluble antigen is present in virus-free extracts of the fixed tissues of guinea pigs, mice, and monkeys during the initial acute stages of experimental infection, and is set free in the serum of patients during the early acute stage of lymphocytic choriomeningitis. Antibodies against this hypothetical denatured tissue protein begin to appear early in the human infection, increasing to a maximum by the early convalescent period and disappearing quantitatively with full convalescence. After their disappearance, viricidal antibodies alone are demonstrable and may persist for at least five years.

This temporal separation of transient and permanent specific antibodies was confirmed by experimental lymphocytic choriomeningitis inoculations of guinea pigs. Tested with soluble tissue antigens, complement-fixation antibodies begin to appear two weeks after the experimental inoculation, reach a maximum by the sixth week, after which they decreased in titer, practically disappearing by the thirty-second week. Neutralizing or viricidal antibodies are not demonstrable till the eighth week, but remain at apparently their full concentration for at least thirty-two weeks, *i. e.*, till after the concomitant precipitin has disappeared. Throughout the period of the experimental infection the concomitant precipitin and viricidal antibodies have no quantitative relationship to each other, being apparently wholly independent serological variables. Mice, similarly inoculated, develop complement-deviating antibodies, but at no time show a viricidal humoral immunity. Nevertheless, the mice become immune, suggesting that the viricidal serum component is a nonessential factor in acquired antiviral immunity in this animal species. That the virus-free soluble specific tissue component is autoantigenic, was shown by its injection into partially immunized guinea pigs, which injection was followed by a marked increase in complement-fixation titer.

Proof of the existence of immunologically inert, secondary antigens and antibodies in certain virus diseases goes far to fulfill prophecies made by certain immunologic theorists [6] fifteen years ago, before the present almost unanimous discard of the historically important specific receptor hypothesis (Ehrlich theory). Whether or not similar concomitant antigens and antibodies are of equal clinical interest in tuberculosis, syphilis and other prolonged microbic infections, is now under investigation in clinical laboratories.

P. O. Box 51.

W. H. Manwaring,
Stanford University.

[5] Smadel, J. E., Baird, R. D., and Wall, M. J.: Jour. Exper. Med., 70:53, 1939.

[6] Manwaring, W. H.: Jour. Immunol., 12:177, 1926.

RADIO-ACTIVATED ELEMENTS IN MEDICINE

When an element is rendered radio-active by bombardment in the cyclotron, it may remain the same chemically or it may be changed to a different element. Its chemical nature has only this importance for biology and medicine, namely, that it may determine its distribution within the body. Any pharmacologic effect which may be characteristic of its chemistry is going to be quite overwhelmed by the very violent biologic effect of its radiation. The radiations from the different radio-active substances are extremely similar and not identical in their biologic effect. Therefore, an understanding of the effect of the radio-active substance depends upon an understanding of the biologic effect of radiation, and the varying radio-sensitivities of the different cells and tissues of the body. The particular radio-active element used will be important from just two standpoints, namely, that its chemical nature will determine the distribution of the radiation through the body, and that the rate of decay will determine the distribution of the radiation effect in time.

Inasmuch as we are well aware of the profound effects of radiation on the body and know that effects can be deleterious or dangerous, therefore the clinical use of artificially radio-active substances for therapeutic purposes must be considered a potentially dangerous clinical experiment and should only be undertaken by those who are well acquainted with the effect of radiation on the human body, and only after thorough study of the effects of the particular radio-active substance in question, investigated by tests in animals.

2361 Clay Street.

John F. Quinlan,
San Francisco.

Why Babies Smile.—There is no evidence to indicate that the smiles of very small babies are caused by conscious thinking, *Hygeia, The Health Magazine* states in a recent issue in answer to an inquiry.

"Observation with a movie camera has recorded that young infants often smile in their sleep," *Hygeia* continues, "but seldom when they are awake unless the skin around the zone near the mouth is gently stroked. The smile seen on the baby during sleep is thought to be of reflex origin, an unconscious act of which the baby may be entirely unaware. It should be remembered that the mouth and the lips are the most sensitive parts of the body in early infancy. Stimuli in this area, from within and without, are readily received and the reflex movement of some of the facial muscles respond to produce the smile."

ORIGINAL ARTICLES

SPINAL LESIONS: THEIR EARLY SIGNS AND IMPORTANCE IN DIAGNOSIS*

RUPERT B. RANEY, M. D.
Los Angeles

SMALL lesions in the vicinity of the spinal canal often give rise to distressing symptoms, yet there may be very few objective signs. Of the various types of lesions which can affect the spinal roots, space-occupying lesions, when recognized and removed surgically, offer the best prognosis. Although these lesions may occur at any level along the spinal axis, they are perhaps more commonly found in the lumbar and sacral regions. Therefore, attention will be given to the clinical aspects of these lower spinal lesions in relation to early diagnosis, prognosis, and treatment.

Low-back pain and "sciatica" are generally the first symptoms of a space-occupying lesion involving the lower spinal roots. Unfortunately, these terms are loosely used in describing low-back pain referred into the lower extremities. Thus, these two symptoms represent a bewildering number of underlying causes. Because of the varied and often obscure lesions responsible for these complaints, a careful analysis of each individual case and an attempt to classify it according to etiology is of extreme importance.

Earlier writers on the subject recognized the character of the many types of low-back pain, even though very few pathologic causes were then known. Cotugni [1] (1764) gave the first accurate description of low-back pain and "sciatica." Vallex [2] (1841) and Lasègue [3] (1864) added to the description, and at present no better account of the symptom-complex can be found. They considered pain of sciatic distribution a disease of the sciatic nerve, and thus the term "sciatica" was coined. "Sciatica," as described by these writers, we now recognize as a radicular type of pain, *i. e.*, pain which originates from a lesion affecting one or more of the lower spinal nerve roots; it is often situated in the vicinity of the lesion and radiates through the body segment of the root involved.

When there is a more universal understanding of the character of pain which emanates from a specific spinal-root lesion, then the differential diagnosis of low-back pain and "sciatica" will be less confusing. Not many generations ago the character of abdominal pain was poorly understood, being considered merely a manifestation of intestinal disease. At present, however, the character of abdominal pain has been analyzed. Thus, we recognize the characteristic pain of cholelithiasis, acute appendicitis, nephrolithiasis, etc. Likewise, if a more thorough investigation of the character of low-back pain with reference into the lower extremities, is made, our efforts will no doubt be rewarded. We shall then be able to recognize variations in type according to etiology, which will greatly help in solving the problem of diagnosis and management.

Steindler and Luck [4] (1938) made an excellent contribution on the subject of low-back pain in relation to injury of the fascia, tendons, and muscles about the lumbosacral and sacro-iliac joints. On the other hand, they did not sharply differentiate it from pain which results from compression of one or more lower spinal roots. Such pain ("sciatica") gives rise to a definite symptom-complex and, in spite of its characteristic features, the underlying cause is too often overlooked. Moreover, the symptom-complex is no longer looked upon as an obscure disease of the sciatic nerve; instead it is regarded as a manifestation of a definite disease, with the actual cause situated in the vicinity of the lower spinal roots.

It is of interest that earlier observers considered trauma a dominant factor in the production of low-back pain with sciatic distribution, and that the trauma was often only trivial. Furthermore, they observed that the "disease" was more common among laboring classes, and that men were predominantly affected. By way of comparison, these observations coincide strikingly with the more recent ones on patients suffering from what we now recognize as posterior herniation of the nucleus pulposus. There is now little doubt that many of the patients of the earlier observers suffered from the same condition. Tumors and chronic infections were occasionally recognized as being responsible for the syndrome, but the cause, in the majority of cases, generally remained obscure. The French writers went so far as to state that syphilis was responsible for "sciatica" in 90 per cent of the cases. Even with the high incidence of syphilis in France, their figures were undoubtedly far from correct.

TYPES OF LOW-BACK PAIN

From a clinical point of view it is important to distinguish between low-back pain of a true radicular nature and other nondescript types. In the former, surgically removable lesions are often responsible, while in the latter, surgery is generally contra-indicated. Although true radicular pain always follows the anatomic distribution of the affected nerve root, there may at times appear to be an overlap into one or two adjacent roots. This, however, is clearly understandable, since a discharge of painful impulses into the spinal cord through a single root may spread to several levels before integration to the level of consciousness. Therefore, involvement of a single root may stimulate involvement of several roots; still the boundaries are within segmental limits.

The pain may also vary considerably in character: (1) there is a common tendency to exacerbation and remission; (2) it is often exaggerated by an increase of intraspinal pressure, *e. g.*, when straining at stool, coughing, sneezing, etc.; and (3) temporary relief is not infrequently obtained by axial skeletal traction. In general, however, persistent or recurring pain radiating through the

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Fig. 1.—Arrow indicates filling defect, involving the first sacral nerve root on the left side. Specimen at right is herniated portion of the nucleus pulposus removed at operation, with relief from symptoms.

anatomic distribution of one or more spinal roots of the lumbosacral plexus, should strongly suggest a space-occupying lesion.

In the nonradicular type of low-back pain another large group of cases is encountered which may be classified under four general subdivisions: (1) Those cases which result from regional organic disease in the skeletal structures, such as trauma, myositis, arthritis, etc.; (2) those resulting from constitutional disorders such as diabetes mellitus, vitamin deficiency disease, etc.; (3) referred pain from pelvic visceral disease; and (4) those that result from suggestion following trivial injury in the presence of minor psychotic states (hysteria, psychoneurosis). In the minor psychotic group the pain generally ignores segmental distribution. On the other hand, it must not be forgotten that "functional" complaints are frequently added to those of organic disease, and, therefore, these cases should receive exceptionally careful consideration. Malingering has not been mentioned because its recognition does not ordinarily offer great difficulty.

Posterior herniation of the nucleus pulposus, with compression of a spinal nerve root, is a common cause of "low-back pain and sciatica," and positive neurologic signs are often obscure. A few signs, however, can frequently be found if a careful search is made. In these cases with a history of back injury (usually minor) and subsequent persisting or recurring pain of a radicular character, there is a strong indication of spinal root compression. The diagnosis of this type of case, then, is dependent on the character of the pain, in equality or absence of deep reflexes, and slight impairment of sensation in the dermatomes to which the pain is referred. If objective findings, *i. e.*, sensory changes and reflex changes, even though ever so slight, are present, the localizing diagnosis is sufficiently certain that contrast media studies need not be done.

In the writer's experience, the lesion has been found at either the fourth or fifth lumbar interspace in more than 95 per cent of cases. If there is a question as to which of the two interspaces is involved, both interspaces may be explored through a reasonably small incision without sacrifice of bone. Thus, the objectionable features of both lipiodol and air can be avoided in a large percentage of cases. If for certain reasons localization is uncertain, with regard to three or four possible levels, then the exact site of the lesion can be determined by roentgenographic contrast media studies (Fig. 1).

Neoplasms about the spinal canal, either primary or metastatic, are also common causes of "low-back pain and sciatica" (frequently the pain is bilateral), and here positive neurologic signs, both visceral and somatic, eventually manifest themselves in abundance. Here again contrast media may be of advantage for localization purposes (Fig. 2).

Of other causes which are occasionally encountered, the history and findings are usually characteristic, *e. g.*, (1) acute spinal epidural abscess, (2) chronic granuloma secondary to tuberculous caries of the lumbar vertebrae, (3) hemangioma of lumbar vertebrae, and (4) metastatic invasion of the lumbar paravertebral lymph nodes from malignant or infectious pelvic visceral disease. In the writer's experience, syphilis not infrequently has been found coincidentally, but on only one occasion did it contribute toward the production of symptoms.

DIAGNOSTIC PROCEDURES

If there is a question regarding the radicular character of the pain, the presence of a space-occupying lesion is doubtful, and a careful search for other causes should be made. In the case of atypical pain, psychoneurosis is often an etiologic factor. In such cases the intraspinal injection of lipiodol should be withheld until more positive evidence of a space-occupying lesion develops; because the mere knowledge that lipiodol is in the spinal canal may serve to cause a marked exacerbation of symptoms. Consequently, a careful consideration of all the facts is essential, otherwise the promiscuous injection of lipiodol into the spinal canal will follow.

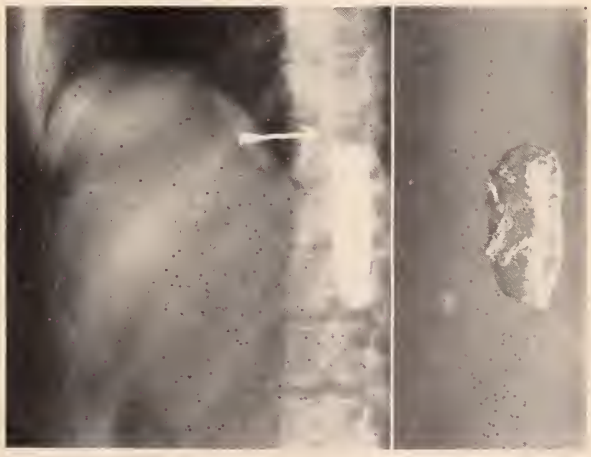

Fig. 2.—Arrow indicates complete obstruction of the spinal canal at the level of the eleventh dorsal vertebra. Specimen at right is neoplasm (meningioma) removed at operation, with relief of symptoms and return of function.

Fig. 3.—Small deformity of the first sacral nerve root on the right side, indicated by arrow. Specimen at the right is portion of nucleus pulposus removed at operation. Following the operation all symptoms disappeared.

The reaction of spinal fluid to jugular compression (Queckenstedt's test) is commonly employed in differentiating space-occupying lesions from other lesions. Therefore, it should be emphasized here that a negative Queckenstedt's sign does not rule out the presence of a space-occupying lesion. In fact the only significance of a positive Queckenstedt's sign is that the lesion has reached a far advanced stage, and caused a complete subarachnoid block. Slight increase in the total protein of the spinal fluid is suggestive of a partially obstructive lesion; however, it should be borne in mind that occasionally spinal obstruction may almost be complete before any material rise in the total protein occurs.

After the diagnosis of a space-occupying lesion is reasonably established, roentgenographic contrast media studies may on occasions be employed for more accurate localization. As a diagnostic measure air has been recommended; however, it is not reliable in all cases, and is valueless unless rigid technique is employed under optimum conditions. Furthermore, correct interpretation of the films requires considerable experience, otherwise erroneous impressions may be gained.

Fig. 4.—Arrow indicates almost complete obstruction at the fourth lumbar interspace. Specimen at right is large protruded portion of nucleus pulposus removed at operation, with complete relief from symptoms.

With regard to lipiodol it should never be used if a localizing diagnosis can be established with reasonable certainty. Neither should it be used as a diagnostic measure in itself to differentiate between nondescript types of "sciatica" and "sciatica" of a true radicular nature. When used with discretion, certain precautions should be taken in order to obtain reliable information. The patient should be in the prone position; the lipiodol should be allowed to travel slowly *en masse* along the spinal canal, the clinician studying under the fluoroscope each vertebral segment as it passes. When a deformity in the canal is seen, a "spot film" should be instantly taken; otherwise, small lesions (Fig. 3) will be entirely missed. Furthermore, if the lipiodol is allowed to rapidly string along the canal during the study, very little, if any, information will be obtained. In the case of a large lesion where obstruction is complete, no difficulty is encountered (Fig. 4).

When the diagnosis of a space-occupying lesion has been established, the studies will usually have given considerable information suggesting the type of pathology present. Tumors, abscesses, granulomas, etc., should receive immediate surgical attention, and, on the other hand, posterior herniations of the nucleus pulposus should be treated conservatively for a reasonable period of time (six to eight weeks) by skeletal traction, correction of posture, etc. If these measures do not give permanent relief, surgery should then be done.

SUMMARY

1. Lesions in the vicinity of the spinal canal often give rise to severe subjective complaints, with very few or no objective findings present.

2. Pain of sciatic distribution is generally the first manifestation of these lower spinal lesions, and should not be confused with the vague pain referred to the lower extremities from other diseases, such as pelvic visceral disease, lumbosacral, and sacro-iliac diseases, etc.

3. The pain of a space-occupying lesion is of a radicular character; it follows the anatomic distribution of the nerve root involved, and does not ignore segmental levels.

4. Posterior herniation of the nucleus pulposus and spinal neoplasms are the most common space-occupying lesions which affect the spinal roots, and diagnosis can be made by the character of the pain, even though very few or no objective findings are present.

5. Roentgenographic contrast media (lipiodol or air) studies may be employed for establishing the exact site of the lesion in certain cases. On the other hand, lipiodol should never be used unless the diagnosis of a space-occupying lesion is reasonably certain, and only when there is considerable doubt as to localization.

6. If the diagnosis has been established, surgical treatment may be expected to give permanent relief from symptoms.

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LOW BACK PAIN: RATIONALE OF FASCIOTOMY IN ITS TREATMENT*

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THE practice of medicine is often accused of a tendency to take up therapeutic fads. This is especially true in the treatment of symptoms such as backache, the causes of which are not clearly understood. It seems pertinent, therefore, to evaluate the scientific basis for the current vogue in this field, which is the division of fasciae and the origins of muscles in the attempt to alter the mechanical forces which act upon the lower back.

Ober,[1] in 1935, presented "a new theory relating to the cause of lame backs." On the assumption that a tight iliotibial band of the fascia lata threw a strain upon the sacroiliac and lumbosacral joints, he divided the tight structures by what is now known as the "Ober operation." A year earlier, Heyman [2] reported the relief of pain over the right sacroiliac joint and right sciatic nerve by means of a stripping operation performed upon the muscles and ligaments which were attached to the posterior part of the iliac crest. These two types of fasciotomy have had widespread use during the past five years, and a rapidly mounting pile of statistics testifies to their efficacy.

FASCIOTOMY IN RELATION TO MAINTENANCE OF POSTURE

The reason for this growing popularity of fasciotomy may be found in a consideration of the rôle of the muscles and fasciae of the back and thighs in the maintenance of posture. An important criterion of posture is the degree of lumbar lordosis. Excessive lordosis produces the hollow back and prominent abdomen so characteristically seen in patients suffering from postural backache. The lumbar lordosis is conditioned upon the angle which the lumbar spine makes with the sacrum and pelvis. The pelvis is thus the keystone to the problem of posture. The tilt of the pelvis depends largely upon the relative tension which acts through the origins and insertions of the various muscles and fasciae which are attached to the pelvic ring.

Tending to tilt the pelvis backward, and thus to flatten the lumbar curve, are the gluteus maximus, hamstring and abdominal muscles, and the posterior part of the iliotibial band into which the gluteus maximus is inserted (Fig. 1). Forces acting to tilt the pelvis forward and increase the lumbar lordosis are the tensor fasciae latae, rectus femoris, sacrospinalis and iliopsoas muscles, and the anterior portion of the iliotibial band into which the tensor fasciae latae muscle is inserted. The fascia lata forms a tubular investment for the muscles and vessels of the thigh and buttock (Fig. 2). Above, it is attached to the iliac crest and other portions of the bony pelvis; below it is attached to the patella and the upper ends of the tibia and fibula. On the lateral aspect of the thigh, the fascia is greatly thickened to form the iliotibial band into which the tensor fasciae latae and gluteus maximus muscles are inserted. The iliotibial band, or tract, with the above muscles, serves as a powerful brace which, in the erect position, helps to steady the pelvis and keep the knee joint fully extended.

Fascial lesions of clinical significance occur in the lower back, the pelvis, and the thighs, which may represent isolated or complementary deformities. The whole fascial system should be considered as a unit which must be studied in the treatment of backache. It should be emphasized that a thorough history and physical examination may reveal the fundamental conditions which have produced the back pain. The fascial deformities may be only secondary to a preëxisting infectious lesion or anatomical anomaly. These considerations should assist one in deciding upon the advisability and type of fasciotomy in the treatment of low backache and sciatic pain.

REFERRED SCIATIC PAIN

This brings us to the subject of referred sciatic pain, a symptom for which many explanations have been offered. One of the favored conceptions at present is the theory of Steindler,[3] who regards the sciatica as a reflex pain having its origin in a derangement of the sacroiliac joint and associated ligaments, the pain impulses from which are referred along the sciatic nerve. An unquestioned, though less frequent cause of sciatic pain is an intraspinal lesion such as a cord tumor, displaced intervertebral disc or thickened ligamentum flavum. A third theory, advanced by Freiberg,[4] postulates the compression of the sciatic nerve against the bone of the sciatic notch by an inflamed or spastic pyriformis muscle. It is apparent that a tight fascia lata may, in a similar manner, compress the underlying muscles which transmit the pressure to the sciatic nerve, as can be seen in the drawing of a cross section of this region. The earliest and often the most striking benefit which follows either the Ober fasciotomy or the posterior fasciotomy of Heyman is the relief of sciatic pain. Such relief may be explained either by the hypothesis of Steindler or by that of Freiberg.

* Read before the Section on Industrial Medicine and Surgery, at the sixty-ninth annual session of the California Medical Association, Coronado, May 6–9, 1940.

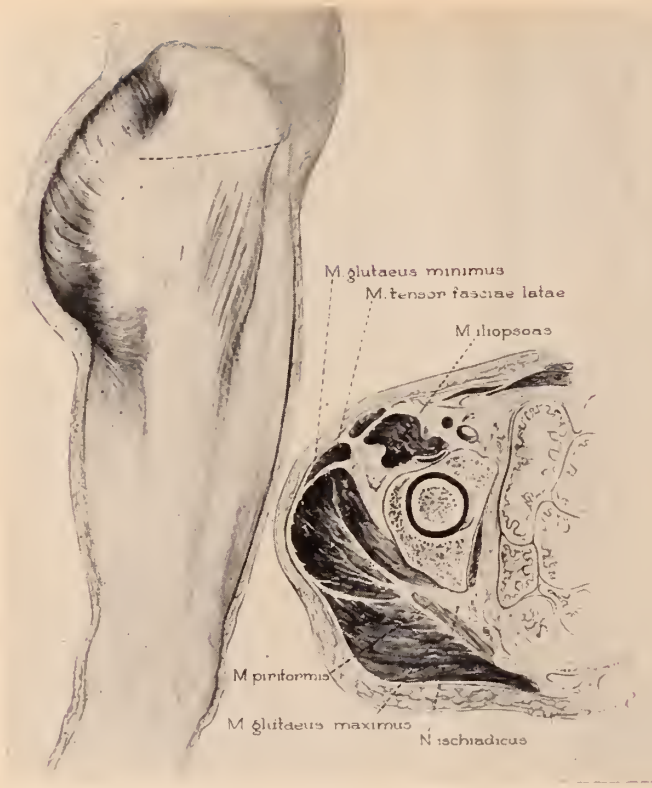

Fig. 1

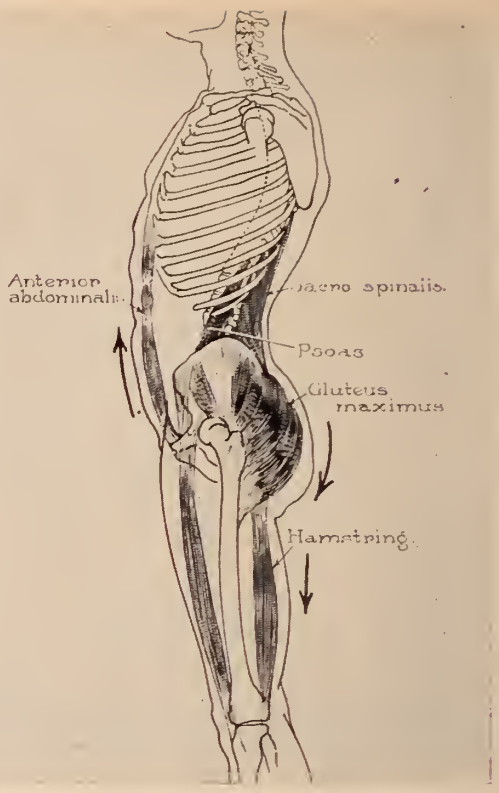

Fig. 2

Fig. 1.—Drawing of dissection to show ilio-tibial band and cross section at level of hip.
Fig. 2.—Diagram showing attachments of muscles to pelvis.

INDICATIONS

The success of these procedures depends, first of all, upon the selection of the proper patients for operation. The general indications for some type of fasciotomy may be summarized as follows: (1) Chronic low-back pain and sciatica. Acute cases should be treated conservatively. (2) The absence of definite organic lesions of the spine or sacroiliac joints, such as tuberculosis, fractures, and tumors. The existence of structural deformities or of a moderate degree of arthritis is not a contraindication for fasciotomy. (3) The failure of the usual orthopedic nonoperative measures, such as support, physiotherapy, traction, and postural exercises. Frequently the latter exercises cannot be performed properly because of tight fascial bands which fix the position of the pelvis.

PROCEDURES OF CHOICE

Having concluded that a given case is suitable for fasciotomy, the surgeon must determine the type of operation to be employed. The following findings point to the Ober operation as the procedure of choice:

1. Tenderness over the sacroiliac joint, sciatic notch, or iliotibial band near the greater trochanter.

2. A positive Ober test for tight iliotibial band. This test is described by Ober,[5] as follows: "The patient lies on his side, with the thigh next to the table, flexed enough to obliterate any lumbar lordosis. The upper leg is flexed at a right angle at the knee. The examiner grasps the ankle lightly with one hand and steadies the patient's hip with the other. The upper leg is abducted widely and extended so that the thigh is in line with the body.

TABLE 1.—*Results of Fasciotomy*

Type of Operation	No. of Patients	Results			
		Markedly Improved	Moderately Improved	Not Improved	Not Known
Unilateral Ober operation	4	3	1	0	0
Bilateral Ober operation	5	3	2	0	0
Unilateral Heyman operation	4	2	1	0	1
Bilateral Heyman operation	4	1	1	1	1
Combined Ober and Heyman operations	3	2	0	1	0
Total results	20	11	5	2	2

If there is any abduction contracture, the leg will remain more or less passively abducted, depending upon the shortening of the iliotibial band. This band can be easily felt with the examining fingers between the crest of the ilium and the anterior aspect of the trochanter."

3. A flexion contracture of the hips, which is due to a shortening of the tensor fasciae latae muscle.

4. An increased lumbar lordosis which the patient is unable to correct by the exercise of pelvic tilting. Following the fasciotomy, some of our patients could readily be taught this exercise. Our present feeling is that the Ober procedure should be bilateral because the tendency to contracture is usually present to some extent on both sides.

The special indications for the Heyman type of fasciotomy are (in addition to the general indications for fasciotomy noted previously): (1) Tenderness over the posterior superior iliac spine and the attachments of muscles and fasciae to it. (2) The temporary relief of pain by the injection of novocain over and around the posterior superior iliac spine. (3) The loss of the normal lumbar lordosis in certain cases.

TECHNIQUE OF OPERATIONS

The technique of these two operations should be described briefly. The Ober operation is readily performed under local anesthesia. The skin incision begins just below and lateral to the anterior superior iliac spine and extends downward and backward to a point one inch above and one inch posterior to the greater trochanter (dotted line in Fig. 2). The iliotibial band and its fascial extensions are divided transversely from the anterior border of the tensor fasciae latae muscle to and including the anterior portion of the gluteus maximus muscle. The cut surfaces of fascia immediately separate for one-half to one inch, and this separation is increased to two inches by freeing the fascia from the underlying muscles. Only the subcutaneous tissue and skin are closed by suturing.

The Heyman operation,[6] is best done under general anesthesia. "A curved incision, about four inches long, is made over the posterior portion of the crest of the ilium and extended about one inch below the posterior superior spine. The gluteal fascia, attached to the lateral lip of the crest of the ilium and to the posterior superior spine, is stripped aside subperiosteally down to the superior gluteal line and to the upper margin of the greater sciatic notch. Subperiosteal stripping is then continued along the medial surface of the posterior spine to the sacrum, and inferiorly to the posterior spine. This removes the iliac attachments of the long and short sacroiliac ligaments. The sacrospinalis fascia is also divided transversely. The subcutaneous tissues and skin are approximated."

COMMENT ON CASES

A series of twenty cases in which one or more fasciotomy operations were performed by the authors forms the basis for this presentation. The series was equally divided as to sex, and the average age was approximately forty years. All patients had complained of low-back pain, while 75 per cent also complained of pain referred to the legs. The duration of symptoms ranged from three months to twenty years. All patients had received the usual types of conservative orthopedic treatment without obtaining full relief. Examination of the patients gave the usual findings which are associated with low backache and sciatica. It should be noted that the Ober operation was performed only upon those patients who had positive Ober tests for tight iliotibial bands. The latter patients usually presented increased lumbar lordosis, which could not be corrected by active effort. Following the division of the iliotibial band it was usually possible for the patient to flatten his lumbar spine. The average length of hospitalization was five days after the Ober operation, and eight days after the Heyman procedure.

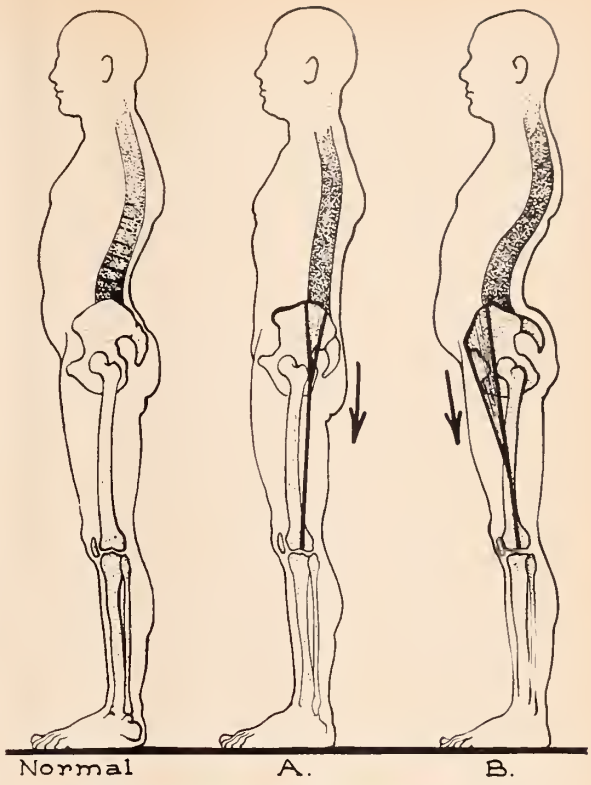

Fig. 3.—Diagram showing manner in which contracted fasciae affect tilt of pelvis.

The types of operation and the results in each case are shown in the table. In brief, of the twenty cases, eleven were cured or markedly improved, five were moderately relieved, two showed no improvement, and in two instances the final result is not yet known.

SUMMARY

The patient with chronic low backache, with or without sciatica, who has failed to obtain relief from the usual orthopedic measures should be regarded as eligible for one of the fasciotomy operations. The choice of the proper type of fasciotomy in a given case depends upon an analysis of the deformities of posture and the deforming forces which are present. In some instances the various types of fasciotomy may be combined.

Fasciotomies offer an opportunity for aiding a fairly limited group of patients suffering from back pain. They are not aimed at the cure of the primary cause of the back pain because the fascial deformities are residual manifestations of a variety of primary lesions. Therefore, the relief of symptoms may not be complete.

In conclusion, these operations should be regarded as supplemental to conservative orthopedic therapy.

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SYPHILIS: THE INTERPRETATION OF SEROLOGIC REACTIONS*

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EXTENSIVE use is being made of the serologic tests in the present campaign to control syphilis. The Wassermann dragnet, the premarital, prenatal, and routine occupational examinations have led to the testing of large numbers of presumably nonsyphilitic individuals. The frequent conflicting reactions obtained have contributed considerably to the already existing confusion, both as to the type of tests to be used and the proper interpretation to be given to the results. The current misconceptions concerning serologic tests for syphilis make it timely to consider critically the more important points regarding their significance.

Much of the confusion surrounding the interpretation of the serologic tests for syphilis is due to a lack of knowledge as to the exact nature of the substance responsible for the positive reaction. Many theories as to the nature of the reactive substance (reagin) have been advanced. The consensus at present regards reagin as a specific altered globulin evoked as a result of infection by the Treponema pallidum.

SPECIFICITY OF REAGIN

While it is not proposed to discuss the mechanism of the serologic tests for syphilis, the question of the specificity of reagin is intimately concerned with the proper interpretation of the results. If reagin is not a specific antibody, or if similar altered globulins may be produced by other infections or changes in the physiologic state (menstruation, fever), the reliance that is placed at present on the serologic tests in the diagnosis of syphilis, in the absence of other evidences of infection, seems unwarranted. Similarly, if reagin or a reagin-like substance is found to be present in the serum of those not infected with syphilis the specificity of the serologic reactions for syphilis must be questioned. While the available evidence is preponderately in favor of the true antibody nature of reagin, this has by no means been conclusively established. Traces of reagin, or of a substance which reacts identically in the Kline precipitation test, have been demonstrated in nonsyphilitic sera by Barnett, Jones, and Kulchar.[1] The occasional occurrence of a similar substance reacting positively to the Kahn test has been reported by Sherwood, Bond, and Canuteson.[2] Kahn,[3] by means of ultramicroscopic precipitation studies, has shown that the type of antibody responsible for the positive serologic reactions is present commonly in human sera in the absence of infection with syphilis. While the amount of reagin-like substance in normal serum is quantitatively small, it is conceivable that changes induced by other diseases or conditions may result in increases sufficient to cause a positive reaction. The frequent positive reactions for syphilis reported in uninoculated animals is further evidence against the specificity of the serologic tests. These considerations should lead one to question the specificity of the serologic reactions, particularly when only partially positive, in the absence of other evidence of infection with syphilis.

DIFFERENTIATION OF REAGIN

Attempts have been made to differentiate the reagin occurring in syphilis from the similar substance known to be present in the sera of those not infected. In an effort to increase the specificity of the reaction, a culture of spirochetes (presumably Treponema pallidum) has been used by Gaehtgens[4] as the antigen. From preliminary studies it would seem the antigen does possess a high degree of specificity (Eagle),[5] but until the authenticity of the culture used is more precisely established and further studies are made, particularly with the sera of patients in whom the positive serologic reaction is the only evidence of infection, the increased specificity of the Gaehtgens test must be considered as yet unproved. As a means of differentiating specific reagin from similar substances, Kahn[6] has recently proposed a "verification test." This is based on the observation that the sera of syphilitics will show a marked precipitation at 37 degrees centigrade and a negative or doubtful reaction at 1 degree centigrade when tested by means of the Kahn test. Conversely, the sera of nonsyphilitics will display a tendency toward a more marked precipitation at 1 degree centigrade than at 37 degrees centigrade. While the specificity of this difference is not conclusively established, and the influence of temperature changes on the other serologic tests should be investigated, it is

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significant that a similar tendency is shown by the sera of lower animals with positive serologic reactions in the absence of syphilis. Experimental confirmation of the hypothesis that reagin is a specific substance must, as Eagle [7] has stated, "await the regular cultivation in quantities of an indubitably and uniformly pathogenic S. pallida." Should further study substantiate the preliminary reports and lead to the adoption of either the Gaehtgens or verification test, the serodiagnosis of syphilis would be immeasurably simplified. The dilemma created by the discovery of a positive serologic test, particularly when only partially so in the absence of collateral evidence of syphilis, would no longer exist.

IDEAL SEROLOGIC TEST FOR SYPHILIS

The ideal serologic test for syphilis should possess both a 100 per cent specificity and sensitivity. It should become positive as soon as infection has occurred and remain so only so long as the Treponema pallidum is active in the body and no longer. All of the available tests, both of the complement fixation and flocculation types, fall far short of this ideal by failing to detect the infection until it has become generalized and by commonly becoming negative, particularly in patients in whom treatment is started during the early stages, before all the treponemata have been destroyed. Furthermore, the reactions frequently remain positive despite prolonged treatment which has rendered the disease inactive from the clinical standpoint, particularly in late and congenital syphilis. All may, at times, show positive reactions in the absence of infection with syphilis.

EVALUATIONS OF CURRENTLY USED TESTS

The evaluations of the past decade have well indicated the deficiencies of the currently used tests. On the basis of the data accumulated by the serologic conferences, Nagle and Willet [8] concluded that a satisfactory test should possess a sensitivity rating of at least 65 per cent and a specificity of 99 per cent (excepting in a few diseases, as malaria and leprosy). These standards should be considered as the minimum or base line, and tests not meeting these requirements be adjusted to conform. The specificity should be increased so as to approach 100 per cent, even if this is done at the sacrifice of sensitivity.

In general, on the basis of sensitivity and specificity, the flocculation tests are equal, or superior, to the complement-fixation tests. Because of their simplicity they are more likely to be performed in the manner recommended by the originator. As fewer variable reagents are required, the tests are more easily standardized and read and should give, when carefully performed, practically identical results in all laboratories. Results of the standard serologic tests do, however, vary considerably with the laboratory, as evidenced by the recent survey of state and local facilities made by the United States Public Health Service.[9] This evaluation well emphasized the need for standardization and control. With identical procedures, for example, the sensitivity of a Wassermann reaction varied from 34.8 per cent in one laboratory to 88.2 per cent in the control series. The incidence of false positives fluctuated from 10 per cent in the hands of one serologist to none in the control laboratory. A knowledge of the proficiency of the serologist performing the test would appear to be of equal, if not greater consideration than the type of test used. As a means of control, the serologist should make frequent intra-laboratory checks, using two or more tests run in parallel, and have the advantage of a clinical evaluation of his serologic reports. From time to time the results obtained should be compared with those secured with identical tests performed in other laboratories. Reports returned by laboratories not fulfilling these minimum requirements for control should be questioned, particularly when the reaction is only partially positive and other evidence of infection is lacking.

SERODIAGNOSIS OF SYPHILIS

In the serodiagnosis of syphilis, reliance should not be placed on a single test, or even on a single type of test, but rather on multiple tests, preferably of both types. The value of multiple tests made in parallel is well indicated by the 26 per cent incidence of conflicting results obtained by Schoch [10] among a large series of patients under treatment for syphilis. The diagnostic efficiency of the serologic tests, Schoch has estimated, can be increased from the present 75 to about 90 per cent through the use of multiple tests.

The more sensitive, rapidly performed flocculation tests are particularly valuable for the rapid exclusion of syphilis, as in selecting a donor for transfusion. The high degree of sensitivity is, however, accompanied by a decrease in specificity, so that false positive reactions are to be expected. Recently, technically simple flocculation tests, designed for office use have been devised. The results are, however, too unreliable for general use and must be confirmed by other tests. The serodiagnosis of syphilis still is, and properly should remain, a function of the laboratory.

REPORT-NOMENCLATURE NOT SATISFACTORY

The practice of reporting the degree of positivity in pluses is not wholly satisfactory. A serum reported as positive "four plus" is often interpreted by both the physician and the patient as being of considerably more serious significance than a reaction reported as "one plus." Since no quantitative measurement of reagin is given in the routine report, the amount indicated by "four plus" in one serum may represent a hundred times or more that contained in another reported with the same degree of positivity. Only by titration can the actual amount of reagin be measured, but technical considerations make the use of a quantitative test impracticable, even though such a report would have many advantages. A committee for the evaluation of the serodiagnostic tests for syphilis, of the United States Public Health Service, has recently proposed a more satisfactory system for reporting serologic results. The committee suggested that the term "positive" includes only strongly and moderately positive reactions (three

TABLE 1.—*Conditions in Which Biological False False Positive Serologic Reactions for Syphilis May Occur*

Frequent	Occasional
Yaws	Febrile states
Leprosy	Chancroid
Malaria	Diabetes
Trypanosomiasis	Mycosis fungoides
Rocky Mountain spotted fever	Tuberculosis
Scarlet fever	Acute disseminated lupus erythematosus
Subacute bacterial endocarditis	Malignancy
Infectious mononucleosis	Lymphopathia venereum
Relapsing fever	Leukemia
	Pernicious anemia
	Measles
	Pregnancy
	Menstruation
	Serum obtained under anesthesia
	Serum obtained after death

and four plus), all weaker reactions being reported as "doubtful positive." The routine use of these designations, particularly the term "doubtful positive" will, it is hoped, lead the physician to interpret the report with greater care. If the "doubtful positive" reports include all equivocal reactions, *i. e.*, every Wassermann test with incomplete hemolysis and every flocculation test with indefinite aggregation, this will comprise a large group which will try the skill of both the serologist and physician. In the absence of clinical evidence a long and searching investigation must be made, since included in this group are many of the biological and technical false positive reactions, and those in whom the positive serologic test is the only indication of syphilis.

Laboratory errors, the use of an overly sensitive test, or very slight variation in the technique, are but a few of the many possible causes of doubtful positive reactions. Increases in the reagin-like substance contained in normal sera, or changes resulting from other diseases, may produce weakly positive reactions in the absence of syphilis. Repeated examinations made at intervals of from three to seven days, using both the complement fixation and flocculation tests, over a period of a month or longer, are often required to determine the significance of the reactions. Inasmuch as doubtful positive reactions are frequently observed in patients with proved syphilis, both treated and untreated, they cannot be ignored.

PROVOCATIVE REACTION

The provocative reaction has long been used to confirm the diagnosis of syphilis. As early as 1913, however, the specificity of the reaction was questioned by Ravaut,[11] who observed a similar effect in the serum of nonsyphilitics following the injection of neoarsphenamin. Subsequent investigations to establish the specificity of the provocative reaction have been made with conflicting results. Because of the controversy, the question of the specificity of the provocative reaction has recently been studied again by Barnett, Kulchar, and Jones.[12] The provocative effect was observed to occur with equal frequency in both syphilitic and nonsyphilitic sera following the injection of neoarsphenamin. Further investigation, by means of either a specific spirochetal antigen or the Kahn verification test, may eventually clarify the questionable nature of the provocative reaction. For the present, at least, it cannot be regarded as a reliable diagnostic procedure.

TABLE 2.—*Procedure for Verification of Positive Serologic Reactions in the Absence of Other Evidence of Syphilis*

1. Check the source of the report and type of test used.
2. Make a careful inquiry and physical examination for evidence of syphilis.
3. Repeat the tests in the same laboratory.
4. Repeat the tests, sending specimens to two or more laboratories.
5. Examine the cerebrospinal fluid.
6. Repeat serologic tests at one to two week intervals for a period of two months or more.

Increased attention is being given to positive serologic reactions for syphilis occurring with other diseases. While leprosy and malaria have long been known to produce a high incidence of false positive reactions, it is becoming increasingly evident that similar reactions may occur in other diseases and conditions. These are summarized in Table 1.

FALSE REACTIONS

The biologic false reactions, occurring with yaws, relapsing fever, malaria, leprosy, trypanosomiasis and infectious mononucleosis, are usually strongly positive and persist for a considerable period. The false positive reactions encountered with the other diseases and conditions listed in Table 1 are frequently weakly positive and transitory, so that syphilis may usually be eliminated by repetition of the tests. The influence of menstruation on the serologic tests for syphilis has long been argued. In a recent study, however, Ingraham and Mayer[13] were unable to demonstrate any effect of the menstrual cycle. Similarly, diabetes has been alleged to produce biologic false positive reactions. From preliminary studies[14] it appears that the serum of patients with diabetes does contain increased amounts of a reagin-like substance which at times may be sufficient to come within the range of the standard tests for syphilis. The frequency of this increase can be correlated with the severity and state of control of the diabetes. Biologic false positive reactions seem to occur most commonly in diseases accompanied by fever or some disturbance of the blood proteins or lipids. The significance of a positive reaction, particularly if there is disagreement between the tests, or if the reaction is only partially positive in patients with other diseases, should be questioned.

In Table 2 is summarized the procedure to be followed to establish the validity of positive serologic reactions in the absence of other evidence of syphilis.

If the diseases known to produce strongly positive serologic tests for syphilis (trypanosomiasis, relapsing fever, infectious mononucleosis, malaria, leprosy, and yaws) are excluded, a persistently positive complement fixation or flocculation test

must be taken, at least for the present, as evidence of infection with syphilis.

CONCLUSIONS

From the foregoing it is evident that the serology of syphilis at the present time is undergoing a change. The existence of two distinct types of positive reactions has been recognized. One, a specific occurring in syphilis, and the other a nonspecific reaction, which may occasionally be observed under normal or pathologic conditions distinctly unrelated to syphilis. In what Kahn[15] has termed "the new serology of syphilis," every positive reaction, unsupported by other evidence of infection, will be subjected to special supplementary study, either by means of a verification test or by as yet undeveloped procedures. The increased recognition given to the biologic false positive reactions through such studies should lead to further investigation of the reasons for their occurrence. From this understanding should eventuate more dependable laboratory tests for syphilis. Whether this will result from the use of a more specific antigen or through some verification procedure is of secondary importance to the fact that, at last, there is at hand a serologic reaction which conforms to the serologic ideal of both a 100 per cent specificity and sensitivity through which syphilis may be diagnosed with certainty. The major objections to routine blood testing shall then be eliminated and the campaign for the control of syphilis immeasurably aided.

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VITAMIN E AND NERVOUS DISEASES*

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ENCOURAGED by the reports of Wechsler[1] and Bicknell[2] on the treatment of certain nervous diseases with synthetic vitamin E, we have, for fourteen months, studied the effects of such therapy on progressive muscular atrophy (nine cases), amyotrophic lateral sclerosis (sixteen cases), progressive muscular dystrophy (twenty cases), amyotonia congenita (three cases), myotonia dystrophica (three cases), multiple sclerosis (eighteen cases), and on one case of dermatomyositis. Previously we had been engaged in neuropathological studies of the nervous systems of suckling rats from E-deficient mothers. Both pathologic changes and clinical signs in these young rats gave us grounds for believing that vitamin E might be of therapeutic value in certain human nervous diseases. Our observations in rats will be reported in a separate paper.

Our clinical report is made at this time, first, because the length of time for which most of the patients have been under treatment has been sufficient to warrant mature conclusions; and, secondly, because the series is large enough to permit comparison of results not only within each category of cases, but also with the recent reports of other investigators.[3]

TECHNIQUE OF INVESTIGATION

All patients, both clinic and private, were examined specially before the treatment was begun and were later observed by us and by members of the Department of Neurology. For the most part, they were not hospitalized. They were all given a list of foods rich in vitamin E which in many instances was supplemented by wheat-germ oil or Wesson oil. Many of them had previously been treated vigorously with vitamin B. When this was not the case, we often prescribed vitamin B complex and/or thiamin chlorid.

Through arrangements made by Dr. Herbert M. Evans, synthetic vitamin E was supplied by Merck & Company in the form of alpha-tocopherol, and by Hoffman-LaRoche in the form of alpha-tocopherol acetate. The Merck product was prepared both in peanut oil for parenteral use and in tablet form for oral administration. One-half of

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our series of patients received the Merck products and the other half the Hoffman-LaRoche tablets. Each patient was assigned a number which was preceded by the letter "M" in the Merck series and by the letter "H" in the Hoffman-LaRoche series.

Treatment was begun with daily doses of 0.030 to 0.050 grams, which were soon increased to a maximum of 0.200 gram. At the beginning the Merck product was administered intramuscularly; later, parenteral administration was abandoned for lack of evidence in its favor and treatment was continued by oral administration.

A group of ninety patients was selected for treatment. However, we are reporting here on but sixty patients because, for reasons beyond our control, the rest received less than forty days' treatment.

The results of treatment are shown in the tables. The expressions, "worse," "unchanged," or "improved," represent a consensus of the observers based on objective clinical signs. Subjective changes reported by the patients are recorded under "comments." As we were aware of the possible errors due to subjective factors in the observer, we attempted to minimize these through independent clinical tests by different investigators, muscular examinations by members of the Department of Orthopedics, and creatin-creatinin studies. The term "unchanged" means that the clinical signs present at the end of the period of treatment were the same as those seen prior to the administration of vitamin E. Many of the patients had been under observation for months or years prior to this investigation. Therefore, in cases of rapid progress of the disease before treatment, a result reported as "unchanged" implies slower progress of the disease than without treatment. The process in these patients is not reported as arrested because we believe even our maximum of fourteen months' treatment is not long enough to judge an arrest. It is our intention to continue to treat the patients still under our care in whom the results suggest arrest or clinical improvement.

COMMENT*

Of the sixteen patients with amyotrophic lateral sclerosis, the disease appeared to be arrested in four. Before treatment with vitamin E, the disease had been rapidly progressive in all these patients for from one and one-half to two years. Cessation of the process cannot be claimed, however, before at least two years' observation of stationary clinical signs. In the six patients reported as unchanged by the treatment, either the disease had been of very long standing and had progressed slowly, or treatment had been given for too brief a period of time to be sure that alterations in the course of the disease had occurred. The remaining six patients grew worse during treatment; that is, they declined at apparently the same pace as before vitamin E was administered.

Thus, only 25 per cent of this series were benefited clinically by the treatment; 37½ per cent were unaffected in any perceptible way although they had been treated for at least 132 days; the remaining 37½ per cent gave inconclusive results.

Of nine patients with progressive muscular atrophy, only one showed clinical improvement. In this case the fibrillations disappeared within two weeks and a gradual increase in strength followed. Six patients showed no change after at least 125 days' treatment, except for cessation of fibrillation in one and subjective improvement in five. Two patients exhibited unabated progress of the diseases despite vigorous treatment for at least four and one-half months. It should be noted that the one patient, M-22, who showed signs of improvement had been ill for only eighteen months before treatment was instituted and received treatment over a longer period of time than any other patient in the series.

Of twenty patients with progressive muscular dystrophy, four, or 20 per cent, showed clinical improvement. In two the improvement was slight, while in the other two the increase in strength was more marked. In sixteen patients, or 80 per cent, the objective signs were unchanged although treatment was given for from 65 to 405 days and most of them were treated longer than six months; nevertheless, the majority reported subjective improvement. Lack of progress of the disease in these patients is suggestive of definite benefits. We feel, however, that treatment over a longer period of time alone can settle the question of positive or negative results in a disease so slowly progressive as this one. In none of the twenty patients was there any objective evidence of further progress of the disease.

Two of three patients with amyotonia congenita showed slow but steady improvement. The motor function in the third patient was unchanged despite vigorous treatment for over a year. This patient had had the disease for eight years and was handicapped by many contractures. The spontaneous recovery typical of this disease naturally must be taken into consideration in interpreting the results.

None of the three patients with myotonia dystrophica showed any benefits whatsoever from treatment with vitamin E. One patient died about four months after the treatment was instituted. The other two patients, who were treated for four and one-half to seven and one-half months, respectively, showed no appreciable benefit from treatment.

One patient with dermatomyositis, who was treated for nine and one-half months, likewise did not show the slightest sign of improvement.

Only two of eighteen patients with multiple sclerosis showed remissions lasting six and twelve months, respectively. Since such eventualities are common in this disease, it would be a fallacy to assume that they had any connection with our treatment. In the entire series, no observable effects on the usual course of the disease, either good or bad, could be attributed to alpha-tocopherol.

SUMMARY

1. Sixty patients with nervous diseases were treated with alpha-tocopherol for periods ranging from 40 to 418 days.

* Owing to lack of space, the statistical data included in the six tables are not printed in CALIFORNIA AND WESTERN MEDICINE. The tables will appear in the reprints.

2. Of sixteen patients with amyotrophic lateral sclerosis, four (25 per cent) exhibited a less rapid progress of the disease after treatment, suggesting but not proving the possibility of arrest.

3. Of nine patients with progressive muscular atrophy, one showed slight clinical improvement.

4. Of twenty patients with progressive muscular dystrophy, four (20 per cent) showed slight to moderate clinical improvement, while none of them showed any objective evidence of further progress of the disease.

5. Of three patients with amyotonia congenita, two showed improvement which may be attributed, however, to spontaneous recovery.

6. Of three patients with myotonia dystrophica, none showed improvement.

7. One patient with dermatomyositis exhibited no improvement.

8. Of eighteen patients with multiple sclerosis, two had remissions of six and twelve months; however, the improvement cannot be attributed to the treatment.

CONCLUSIONS

Our results during fourteen months' experience with alpha-tocopherol in the treatment of sixty patients with nervous diseases do not warrant an optimistic view. We feel that the conditions dealt with in this investigation are not reversible; that they are degenerative diseases, the improvement of which depends rather upon general care and good environmental conditions than upon any specific therapy. Therefore, we conclude that the most one can expect from vitamin E therapy is retardation of the disease process.

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PROFESSIONAL PREPAREDNESS*

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ON September 1, 1939, the mad dogs of war were again unleashed by the powers of Europe. Since that day no people or nation of the world has escaped the effects of the ravages of their wild destruction. You will recall that when the fateful words were radioed from London to the far corners of the earth that England was at war with Germany, great ocean liners blacked out their lights, shifted their courses and fled like phantom ships along uncharted sea lanes. Since that time we have witnessed the collapse and capitulation of great nations, the enslavement of free men, the persecution and banishment of racial minorities, the destruction of ancient cities, the brutal slaughter of millions of men, women, and children—the ravages of famine, disease, and poverty. And yet twenty years before we said it could never happen again.

What we failed to realize was that the last World War had created new forces—evil forces—that by the terms of the victory treaty at Versailles we had unlocked a Pandora's box and set free evil spirits to bring about our undoing. And when the hurricane brewed by these evil forces broke upon us we were unprepared. We had fallen asleep at the switch and neither heard nor saw two opposing philosophies of life racing toward each other with inevitable collision and destruction.

We must face another fact. We shall never again know a world as it existed prior to September, 1939. The political, economic, and social structure we will build upon the ruins of the old order will be something different from what we have known before. It may not be to our liking; or it may be a nobler, a richer, a better life than we have ever experienced or dreamed about. But we know it will be different, new and challenging. We should be thinking about that new order now, today—we should be preparing for it. I am sure we are in agreement that the new order should be built upon the foundation stones of our free, democratic way of life. Today we have covered the sides of our new men-of-war with sheet steel which is impervious to the stealthy torpedo, yet the fundamental principles of ship construction are the same as in the days of the Spanish Armada. And similarly we need not change the principles of governmental construction, but the new temple of democracy that will be erected should be more habitable, more spacious, more livable to meet the needs of new human requirements.

MEDICINE AND LAW ARE ANCIENT AND LEARNED PROFESSIONS

We are members of ancient and learned professions. Down through the centuries law and medicine have marched side by side liberating and enriching human life. The first individual phy-

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Address given before the San Francisco Chapter of the California Public Health League, November 25, 1941.

sician, Sekhet-enanch, an Egyptian, practiced his profession 3000 B. C., and a Babylonian king, Hammurabi, chiseled a code to govern human behavior 2250 B. C. To men of medicine the immortal names of Hippocrates, Galen, Avicenna, Vesalius, Harvey, Morgagni, Hunter, Laennec, Bright, Jenner, Pasteur, Koch, Virchow, Lister, Erlich, and others, are beacon lights that illuminate the past and inspire and point the way to new achievements. To men of law the names of Confucius, Solon, Moses, Justinian, Grotius, Blackstone, are only a few of the great lawgivers who gave us a political society governed by law, insuring to the individual liberty, equality, and justice.

PROFESSIONS ARE A PART OF THE EXISTING ORDER

Our learned professions cannot be divorced or exist independent and apart from the political and economic order in which they function. We have achieved our greatest successes and made our greatest contributions to the welfare of humanity under a system of government which granted the maximum of freedom and private enterprise and which encouraged individual initiative. Wherever the state forces the submission of the learned professions to the regimentation of bureaucratic, autocratic control, the lights of political and scientific advancement grow dim, and law and medicine become sterile and decadent.

TODAY'S POSITION OF THE PROFESSIONS

What position do we members of the learned professions find ourselves in today? Well, today we are free in America. But what about tomorrow? Is there one here present who will guarantee our professional independence tomorrow? We have all heard the apostles of collectivism preach their program of socialized law and medicine. Will we supinely engage in wishful thinking that "it can't happen here" until we hear the harsh knuckles of an authoritarian government knock at our office doors? The tremendous concentration of power in government today to meet the need of national defense will assuredly not be wholly relinquished when peace comes again. Rights once surrendered are too often rights lost forever.

These are not alarmist statements. They are cold, realistic facts. Lewis T. Buckman, President of the Medical Society of the State of Pennsylvania, speaking at Pittsburg, October 7, 1941, cogently declared:

> Medicine stands alone with the farmer, the business man, and the professions who have always depended on individual initiative and personal effort. We see about us the centralization of power in the state; we are stirred to fight against totalitarian aggression elsewhere in the world, and yet see all about us the entrenchment of such another form of state socialism.

Now, what is the answer to Doctor Buckman's diagnosis of this malady of state absorption of the learned professions? With your permission I would like to offer an answer through the general expression, "professional preparedness." We admit a condition exists which requires a remedy to preserve the patient's health and life. We cannot correct the unhealthy condition by allowing the patient to pursue habits which precipitated the condition. Preventive medicine for our professional health is demanded. A supervised course of treatment, religiously adhered to by every member of the profession, is necessary. And the remedy may be found in the primary causes of the disease.

WHY ARE THE LEARNED PROFESSIONS ON THE DEFENSIVE?

In the hope that you will not deem me presumptuous, may I enumerate a few of the causes which, in my opinion, have put our professions on the defensive. There are three causes that come to mind. There are doubtless others, but, I believe, we can all agree on the following:

I. *First,* we have been too absorbed in our own individual practice and pecuniary gain, and have neglected our professions as a whole and the organizations representing them.

Robert Maynard Hutchins, President of the University of Chicago, speaking to the American Bar Association in September, 1937, had this to say:

> A profession is not simply a collection of individuals who get a living for themselves by the same kind of work. . . . It is a body of men who carry on their work in accordance with rules designed . . . to impose on the profession itself the obligation of maintaining the quality of service, and to prevent its common purpose being frustrated through the undue influence of the motive of pecuniary gain upon the necessities or cupidity of the individual.
>
> A profession must at least be "free from the vulgar subordination of moral standards to financial interests." But that is not enough. It must also be directed to serving the interests of the community. When a prominent business man says in announcing an important deal, "Our only motive is to make a profit," we may be permitted to doubt whether business is yet a profession; and in view of the activities of some of our brethren we may wonder whether the law has remained one.

Now, Doctor Hutchins was not making a blanket indictment of the entire legal profession. We can agree, however, that such a tendency should be sternly condemned. No professional man should be too busy to contribute some time to the improvement and the protection of his profession. We, individually, are no greater than the profession of which we have the honor and privilege of being a member. It is our duty to support it and the organizations which speak for it.

II. *Secondly,* we are too conservative as professions. We tend to lag behind the onward march of progress.

Of course, today we are living in an abnormal period. Our entire civilization is in a state of upheaval and the spirit of the times is change. But even in normal times history will show that the professions have trailed the field, and in many instances even balked until a new wave of change pushed us forward into an established system we had so lately refused. If we expect to have a virile, progressive profession, we must adjust and adapt ourselves to the natural evolution of society. During periods of world upheaval we must meet and overcome the problems that confront us.

Lest there be any misunderstanding of the remarks just made, let me say that by adapting ourselves to change I do not mean that we are to experiment and try every idea that some self-appointed

saviour of mankind unselfishly offers to an unappreciative world. Nor should we discard the old until a newer and better method has proved itself. But there is a happy medium, it seems to me, of recognizing that situations exist which call for a solution and then conscientiously attempting to find that solution.

As an example of such a problem let us consider the widespread belief, whether true or untrue, that a large proportion of our population is without adequate medical care and attention. Now one way to treat this very real problem is to ignore it, let nature take its course and oppose any organization which attempts to capitalize upon this popular belief. But enlightened medical organizations have been meeting the problem by investigation and providing all the public with skilled and competent service. You have today your *California Physicians' Service* which is attempting to meet the challenge of that problem. Undoubtedly there is room for improvement and amplification, due to facts you have learned from its operation since its inception. As long as there is any criticism about any activity of our profession we should strive to correct the cause of the complaint. Whether all the organic parts of your professions are functioning perfectly is best known to yourselves. If not, then something should be done about it.

Certainly there is room for improvement in the legal profession. For years there has been a hostile clamor from the public that justice be speeded up—that our rules of procedure be simplified and the expense of litigation be reduced. For years nothing of any importance was done to satisfy this public demand. It was only until we found ourselves faced with the competition of a horde of quasi-judicial administrative boards which heard and determined controversies between our citizens—boards which allowed laymen to appear before them and represent contesting parties—that we awoke to the need of reform. In the last decade the bench and bar of America have studied, introduced and adopted far-flung programs of speeding up the judicial processes and improving the administration of justice. The fact that we are applying ourselves to this task today, however, does not excuse our neglect of the past or our failure to recognize and solve the problems as they arose.

May I pause here to pay tribute to a great lawyer and jurist of California. The bench and bar of our state are particularly fortunate in having the Honorable Phil S. Gibson as Chief Justice of our Supreme Court. Since his elevation to that high office Chief Justice Gibson has used his position of leadership to recommend and secure much needed reform in the administration of justice. His spirit of devotion to the improvement and progress of the law exemplifies the highest traditions of our profession.

III. *Thirdly,* we have lacked a sufficient interest in the processes of government. Our professions would suffer the most under a totalitarian régime. Our professional independence, the advancement and progress of our professions, is dependent upon the maintenance of our free, democratic way of life. The laborer, the business man, the farmer, could pursue his regular vocational functions in practically the same way under state socialism as under our present system. But from the very nature and function of our professions, state socialism or any system of socialized medicine or law, would mean the extermination of our professions as such.

We have a government of laws. It is important that we take an interest in the laws of our state and nation. We should be familiar with the laws that affect us and our professions. We should inaugurate and support legislation which raises the standards of our professions. We have as an example of this forward-looking program of the medical and dental professions the proposed *Basic Science Initiative.* If every member of your professions will lend his whole-hearted support to this measure, its successful outcome at the polls will be assured.

Another example of professional coöperation was demonstrated this year when my alien *Physicians' Reciprocity Bill* was passed over the Governor's veto. The support of the organized members of the medical profession was the important factor in finally securing passage of the bill.

I wish to take this opportunity of publicly expressing my deep appreciation to an eminent member of the medical profession, Dr. Aaron J. Rosanoff, distinguished director of the State Department of Institutions. The advice and suggestions he gave me in the preparation and passage of the reciprocity bill were invaluable. His personal endorsement of it carried great weight with the legislature. Doctor Rosanoff, serving in his present position at great personal sacrifice, represents the true spirit of professional preparedness. As a legislator, it is my observation that our state institutions were never more competently administered. It is a great source of satisfaction and pleasure to me to pay this small tribute to Doctor Rosanoff.

OBLIGATION OF MEMBERS OF THE LEARNED PROFESSIONS

It was Goethe who said:

> The possessions which you have inherited from your ancestors—earn them in order truly to own them.

How appropriate is this admonition to the learned professions. We are the beneficiaries of a great heritage bequeathed to us by our illustrious predecessors. But, like most beneficiaries, we are inclined to accept our inheritance with little thought as to the blood, sweat, and tears by which it was acquired, nor do we devote our best thought and effort to its protection, perfection, and perpetuation.

We should be leaders, not followers. We should be originators, not imitators. We should be builders of new bridges that will carry humanity to richer fields of human endeavor. These are precedents—solemn obligations, imposed upon us by our professional heritage and implied in the license to practice our profession granted us by our sovereign state.

A favorite title for an address is "Medicine at the Crossroads," or "Law at the Crossroads." In the minds of many people, we are always at a cross-

road which has no sign to direct us forward to our desired destination. There are no crossroads in the learned professions. There is only one road—a straight road, well marked and centuries old.

On the gravestone which marks the resting place of a great American lawyer and statesman, William Henry Seward, are these words, "He was faithful."

Let us be faithful to our professional heritage. Let us dedicate our individual efforts in the future so that when the time comes for us to give way to our younger brothers who will follow in our footsteps it may be said of each of us, "He was faithful."

Third and Spring Streets.

VISUAL DISTURBANCES FOLLOWING HEAD INJURY*

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Of all the special senses, vision and hearing are valued far above the others. The mechanisms concerned in normal vision are numerous and, in the majority of serious head injuries, some part of this elaborate scheme is temporarily or permanently affected (Russell[25] and Strauss and Savitsky[27]). In this paper, injuries of the optic nerve and their posterior connections are considered from the neurosurgical viewpoint.

A few generalities may first be made regarding head injuries. It is demonstrated frequently that an insignificant blow on the head may cause extensive intracranial damage of almost any variety. The fact that consciousness was not lost is no assurance whatever that the brain or cranial nerves have escaped injury. A patient may have a large depressed fracture with contused brain beneath, and not even be dazed by the impact. This is illustrated in another way by Mock,[19] who, in 1939, estimated that in the United States every year there were 150,000 fractured skulls and 450,000 serious cerebral injuries. The presence of a linear fracture of the skull is of little consequence if other intracranial injury has not been received. A basal fracture tends to radiate along the bone that is most easily broken or separated. Finally, in civil life, the majority of head injuries that affect vision are inflicted by falling in one way or another (Davidson[8]).

The portions of the optic pathways most frequently injured are the optic nerves, the optic chiasm, the visual cortex, and the visual association areas (Cohen[5]).

INJURIES OF THE OPTIC NERVE

Excluding bullet wounds of the head, the orbital portion of the optic nerve is almost never injured by bone fragments (Ballantyne,[2] Pringle[21]). This is largely true even of the portion in the optic canal. Most orbital fractures are in the thin roof, being a continuation back of a fracture following a blow on the forehead or face. Callan[4] theorized that such a fracture tended to follow the frontoethmoidal suture to its union with the frontosphenoidal and ethmosphenoidal sutures, where it continued back across the lesser wing of the sphenoid to involve the optic canal. Pringle expressed the contrary view that the fracture line more commonly traveled medially in the ethmosphenoidal suture, sparing the optic foramen. He examined at autopsy 136 cases of fractured skull and no direct injury of the optic nerve was found. In thirty-eight cases of orbital roof fracture on one or both sides, twelve of them had a fracture into one or both optic foramina. He found anterior clinoids fractured in five instances, and the posterior clinoids fractured in six. Naffziger[20] observed a fractured anterior clinoid process that had compressed the optic nerve to about one-third of its normal width. Barkan and Barkan[3] pointed out that the optic nerve in the optic canal is attached by arachnoid to the dural sheath more intimately superomedially than elsewhere. They felt that a fracture of the upper inner wall of the canal would be particularly likely to damage the nerve by splitting the arachnoid. Rollet, Paufique, and Levy[24] felt that x-rays could be expected to reveal optic canal fracture if taken soon after the accident. Davidson,[8] in twenty-two cases of optic canal fracture, found x-ray evidence of narrowing in only one.

Monocular blindness, following a head injury, is usually attributed to hemorrhage into the dural sheath of the optic nerve, especially if the blindness comes on or if it increases after the accident. In some instances the hemorrhage is continuous with a subdural collection, but several cases have been reported in which separate intravaginal bleeding was found. Cohen and Miceli[18] reported cases in which the subarachnoid space around the optic nerve was distended by clear fluid that compressed the nerve severely. The typical history of intravaginal hemorrhage is of a diffuse blow on the forehead, with or without symptoms of concussion, after which vision in one eye is impaired or absent. Barkan and Barkan found sector-field defects accompanying optic nerve injuries. They postulated that, when the macular bundle is spared, the pupil reacts to light, but that if the macular bundle be injured there is a central scotoma and absence of the direct pupillary response to light, even though the eye be not completely blind. They stated that a sector defect up to and including the macula was characteristic of an injured optic nerve. Various investigators have found that, if blindness persist, optic atrophy appears in a few weeks and sometimes as early as six days (Davidson). In a few cases of blindness from slight optic nerve injury, spontaneous recovery has occurred in from a few hours to several months.

Some authors (Pringle, Eagleton[9]) have advocated, and employed, surgical exposure of the optic nerve to drain an intravaginal hemorrhage. The results have not been good, but usually the interval between accident and operation was very

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long. Possibly earlier operation might have been more successful. Eagleton described an operative approach to the orbital roof by dividing the upper anterior portion of the temporal muscle and entering the anterior fossa beneath the outer part of the frontal lobe.

Three cases are on record of fracture in the optic foramen without appreciable effect on the optic nerve until some months later, when callus formation compressed the nerve, producing monocular disturbances (Lillie and Adson,[16] Clovis Vincent[28]).

Adhesive arachnoiditis (Ballantyne, Craig,[17] Holmes,[13] Cushing,[7] Russell[26]) is a poorly explained condition that may affect the intracranial portion of the optic nerve, causing signs and symptoms suggestive of pressure by a tumor. The history is sometimes obtained of a head injury a few months before, with the later onset of gradually dimming vision. Operation reveals thickened arachnoid around the optic nerves and liberation of the adhesions sometimes clears up the condition or halts its progress.

REPORT OF CASE

R. S., twenty years old, was involved on September 13, 1939, in a car accident, being thrown to the road. He was unconscious momentarily, and then dazed for a short while. He had a contusion with macerated scalp in the right temple, fracture of the right zygoma, fracture of the nose and a fracture through the left petrous bone. Both eyes were swollen shut. Three days later, when the bandages were removed, the right eye was blind and the left face paralyzed. A month after the accident the right eye was still blind, and the disc was bluish-white and sharply outlined. There was well-developed papilledema in the left eye. Seven months after the accident the right disc was yellowish-white and the left still showed papilledema. The left visual field, on the perimeter, was contracted to 50 degrees with a blind spot twice normal size. Sixteen months after the accident the right eye was still blind and the left disc blurred, but less elevated. He complained of slightly impaired vision on the left and found that the eye often felt dry while he was driving in his car. It seems likely that, whatever happened to the right optic nerve, the left was compressed by hemorrhage in the dural sheath. X-rays of the optic canals showed normal contour. The dryness was explained by interruption of the secretory fibers to the lacrimal gland as they traversed the left middle ear, in the greater superficial petrosal nerve.

INJURY OF THE OPTIC CHIASM

The chiasm may be torn when a severe fracture splits the skull in the olfactory groove. Coppez[6] decided from experiments that a separation of bone in the midline of 26 millimeters or more was likely to tear the chiasm. The tear is most often in the midline, from in front, resulting in a bitemporal hemianopia. Sometimes, one optic nerve is completely divided as well, so that there is vision only in the other nasal field. Rand[22] found in two cases a chiasmal lesion after a blow on the vertex. He explained it by a downward thrust of the cranial contents with a sudden forcing forward of the fluid in the third ventricle, against the chiasm.

INJURY OF THE VISUAL CORTEX

It is in this location that many head injuries have their effect on vision. The calcarine cortex may be the seat of concussion, edema, contusion, laceration, compression by depressed skull fragments or compression by a hematoma. The plan of cortical localization, as described by Holmes,[14] has been found to agree with clinical observations of other authors. The upper and lower lips of the calcarine sulcus represent the corresponding upper and lower halves of the retina. Peripheral vision is received, finally, in the anterior portion of the calcarine area, whereas macular vision is represented in the region of the occipital pole. Holmes further assigned the horizontal meridian of the visual field to the lips of the calcarine sulcus, and the vertical meridian to the cortex in the depths of the sulcus.

Careful neurologic examination is necessary to locate the intracranial lesion, but, to decide its pathologic character, one must rely largely on the course of the condition. In mild concussion of the occipital lobes, when consciousness is not lost, there may be partial or total blindness in one or both visual fields for a few minutes or even an hour or two (Anderton[1]). If localized cerebral edema develop, the visual complaints may not be at their worst at once, and will last for, perhaps, a few days. Hine[12] stressed the fact that after a concussion a slight lesion may only produce a visual field defect for colored objects. This dissociation of white and colored objects was not found in cases of intracranial hematoma with field defects. He pointed out that when a blow is received in the occipital region, it is usually above the occiput, so that the upper calcarine area is the more severely affected, resulting in an inferior quadrant hemianopia. He reviewed six cases of occipital concussion with field defects and most of them had a split macula. Strauss and Savitsky also stated that the field defect might be for colored objects only. They found ring scotomas after head injury, detecting them only on the tangent screen. No good explanation was offered to account for these scotomas, but it was suggested that fatigue might constitute one factor. Ingham and Lyster[15] reported a patient with depressed fracture above the occiput who did not lose consciousness. He saw a flash of light and was then momentarily blind, following which a symmetrical horizontal inferior hemianopia remained. Two days later the hemianopia was present only for smaller test objects.

In cerebral contusion the symptoms are more severe and of still longer duration. In addition, there is subarachnoid hemorrhage, so that a spinal puncture would show bloody fluid and there might be photophobia from meningeal irritation. H. W. Grant[11] found fields concentrically contracted to 10 degrees in a man who had been unconscious for about ten minutes after a car accident. In two months there was complete recovery. Rand reported concentrically contracted fields in several patients after head injury, but attributed it to hysteria. It is likely that a contusion, and certain that a laceration, would leave some permanently damaged brain tissue.

Riddoch[23] stated that, in recovering lesions affecting the visual fields, appreciation of motion was the earliest function to appear, and that if this were found in the first few months after injury

the prognosis was good for continued return of vision.

INJURY OF VISUAL ASSOCIATION AREAS

This is the cortex adjacent to the calcarine area, including most of the occipital lobe and particularly its medial surface. Here are located the higher mental processes concerned with vision, the essential function being to interpret what is seen and to integrate the information in the light of previous experience. Disturbances of this function may cause such symptoms as obscure difficulty in reading (Edwards[10]) and in following the thread of a story, difficulty in understanding what is read, or in recognizing what is seen. In right-handed individuals the speech center resides in the left hemisphere, which is then called the major hemisphere. Injuries of the visual association areas in the major hemisphere are more likely to interfere with visual-speech mechanisms than if the injuries occur in the minor hemisphere. Ballantyne reported two cases of word-blindness after a head injury.

Holmes concluded that lesions on the lateral surface of the hemisphere, even as far forward as the posterior parietal region, may disturb the higher visual perceptual functions, resulting in loss of visual orientation and localization in space, loss of perception of depth and distance, also visual agnosia, and loss of visual attention. Strauss and Savitsky describe many subtle forms of similar disturbance. One patient could read without being able to recognize the individual letters. Westcott[29] examined seventy-two patients with so-called accommodative asthenopia after head injury, but decided that, in 65 per cent of them, the real trouble was in the higher cerebral association centers.

The primary objective in examining the visual mechanism after a head injury is to decide on any treatment which may improve the final outcome. The second aim is to form an opinion regarding the prognosis. The appropriate treatment is indicated only by an accurate diagnosis as to location of the lesion and its pathologic characteristics. Surgical measures sometimes can relieve symptoms due to compression by bone, edema, hemorrhage or by adhesions. The difficult part of the work is early diagnosis, so that any indicated measure can be applied as soon as possible after the condition appears. The risk of such surgical intervention is usually not great and is negligible when balanced against the possibility of obtaining better vision for the patient.

SUMMARY

1. In civil life most injuries producing monocular disturbances are the result, not of damage by bone fragments, but of compression by other means, particularly hemorrhage in the dural sheath of the nerve. The prognosis is grave, but it is conceivable that if such a hemorrage were drained promptly vision might recover better.

2. Bony callus may form at a fracture line in the optic foramen, causing compression of the optic nerve.

3. Adhesive arachnoiditis may develop some months after a head injury and cause serious impairment of vision in both eyes.

4. Injury of the visual cortex produces a wide variety of signs and symptoms, sometimes with dissociation for color, appreciation of movement, and for form.

5. Many patients with vague but persistent difficulty in reading, following a head injury, have a cortical lesion in the visual association areas. Formerly the tendency was to attribute the complaints to a neurosis if no eye muscle imbalance could be found.

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ASPHYXIA NEONATORUM*

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WHEN discussing the resuscitation of the newborn infant with asphyxia, it has been customary to begin with a consideration of what factors normally operate to initiate respiration. However, it is now generally accepted that the respiratory mechanism does not begin its function at birth, but that it normally begins some time during fetal life *in utero*. This has been ably demonstrated experimentally in various animals by Wislocki,[1] by Snyder and Rosenfeld,[2] by Bonar,[3] and by Windle and Becker.[4] There can be little doubt that this occurs in the human fetus, as it has been observed directly during cesarean operations, and indirectly through the abdominal wall of the mother.[5,6] The suggestion has even been made that the resultant aspiration of amniotic fluid may normally aid the "dilatation and differentiation of the alveoli."[6]

Furthermore, it has been shown that these fetal respiratory movements, in animals, are sensitive to drugs and gases administered to the mother. Maternal anoxemia of a degree which only stimulates maternal respirations may depress or abolish the fetal respiratory movements; CO_2 deficit, likewise, will depress fetal respirations; but CO_2 excess has little, if any, stimulating effect. Drugs which barely produce maternal analgesia may completely abolish the fetal respiratory movements.[2,4]

Therefore, it would seem more constructive that we should forsake the old concept that respiration starts at birth. It would be better to follow the suggestion of Snyder, Bonar and others, and consider an infant's first respiratory effort after birth not as the initiation of a new mechanism, nor as the awakening of a dormant function, but as the continuation of a vital process which functioned from time to time *in utero* and which was interrupted during birth.

It is not difficult to understand why the respiratory mechanism is so often seriously altered by delivery. A newborn infant may well be considered as suffering from some degree of shock as the result of even minimal birth trauma.[7] In addition, the baby is often under the influence of depressant drugs administered to the mother. Maternal analgesics are seldom without some effect on the infant; often this effect is considerable, as in the case of morphin, ether, sodium pentobarbital, or paraldehyd.[8] And, finally, in addition to the two handicaps—shock and narcosis—there is often the possibility of other less obvious factors, such as hemorrhage or defects (organic or functional) in one or more vital organs.

When, as a result of these factors, shock and narcosis, respiratory function fails to recover quickly, another seriously damaging process, anoxemia, begins to add further injury. The effect of anoxemia on the vital nerve centers, which control respiratory and vasomotor reactions, is to depress further their sensitivity. Yandell Henderson[9] has contended that, inasmuch as the respiratory center is depressed by oxygen lack, it requires a stronger stimulus to produce activity. However, there is little direct evidence to support this contention, and there is experimental data tending to refute it. Schmidt[10] has shown experimentally that when anoxemia has progressed to the point where the respiratory center is depressed, stimulants such as CO_2, various drugs (atropin, camphor, strychnin, caffein), or increased acidity, not only fail to stimulate but even act as further depressants.

Eastman[11] has measured the principal biochemical changes which occur in the blood of asphyxiated newborns and compared them with similar studies of normal newborns. In asphyxiated infants there is primarily a decrease in the oxygen content of the blood, a marked increase in lactic acid, a lowered blood p^H, and an increased CO_2 tension. In some of Eastman's patients the blood p^H fell to the lowest limits compatible with life, and in two fatal cases the p^H was below 7.0. Eastman feels that this severe acidosis is due to fixation of base by accumulated lactic acid, and to a CO_2 excess which cannot be removed through the normal channels of placenta or lung. Similar findings have been reported by Wilson, Torrey, and Johnson.[12]

In view of these considerations, supported by clinical experiences, it would seem that the fundamental immediate need of the asphyxiated baby is oxygen, and that respiratory stimulants such as CO_2 or various drugs are superfluous and may be even harmful.

SEQUELAE OF NEONATAL ASPHYXIA

Realizing that anoxemia, if severe or prolonged, causes cell death, the question, naturally, arises whether prenatal or neonatal asphyxia of a degree insufficient to cause the death of the total organism may result in permanent defects of the nervous system. We are interested especially in injury to the nervous system because nerve tissue is especially sensitive to anoxemia and an injured nerve cell cannot be replaced; whereas injuries to other organs can, to a much greater extent, be functionally repaired.

There are experimental data concerning the effects of anoxemia on the nerve cells of animals. Anoxemia will raise the threshold and decrease the conductivity of isolated nerve segments.[13] Yant and his coworkers[14] found that in dogs anoxemia

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Read before the Section on Anesthesiology at the seventieth annual session of the California Medical Association, Del Monte, May 5–8, 1941.†
† Since this paper was written, an excellent report of the pathological effects of asphyxia has been published by Clifford. (Clifford, S. H., Journal of Pediatrics, 18:567, 1941.) This study was made on eleven infants asphyxiated in utero and delivered by cesarean section, thus eliminating possible effects of birth trauma.

produced severe hyperemia and blood stasis, with petechial hemorrhages especially in the brain stem. The nerve cells found to be most sensitive to anoxemia were the outer cells of the cortex, cells of the thalamus, the visceral efferent nuclei, and the correlation and sensory centers of the brain stem. Thorner and Lewy,[15] after exposing guinea pigs and cats to sublethal periods of anoxemia, examined the brains at various intervals following recovery. They found degenerative changes in nerve cells, perivascular hemorrhages; and in animals which were killed after repeated periods of anoxia, some mild fibrosis of the meninges and blood vessels was also found. A most interesting observation in these experiments was that the animals showed no detectable impairment of function during the intervals between induction of anoxemia, even though the brain lesions were later found to exist.

Steegman,[16] reviewing published observations and experimental data says, "The cortical ganglion cells of man can probably withstand deprivation of oxygen for two minutes, but after five minutes irreversible degenerative changes occur."

It is more than probable that similar lesions occur in the newborn infant as a result of asphyxia. Cases have been reported in which the autopsy revealed no gross cerebral hemorrhage, but scattered areas of nerve cell degeneration, edema, and petechial hemorrhages presumably due to anoxemia.[17,18] The difficulty in interpreting accurately these findings is that the traumatic effect of delivery upon the head cannot be discounted. It is known that concussion injuries to the head will produce the same pathologic picture as anoxemia,[17] and that the spinal fluid of apparently normal infants may be blood-tinged.[19] Furthermore, retinal hemorrhages are frequently found in newborn infants,[20] and are probably due to factors arising from trauma as much as from asphyxia.

Attempts have been made to investigate the late permanent effects of anoxemia upon behavior. Schreiber [21] relates the case of a 27-year-old female secretary who was asphyxiated in a closet during a fire. She was rescued unconscious, and gradually recovered in the hospital. However, she required three years to relearn the use of a typewriter, and she underwent a complete change of personality, involving her memory, her judgment, and her behavior. Data based upon a birth history of asphyxia, however, is more speculative than accurate. Penrose,[22] in a study of 1,280 cases of mental defect, mentions the frequency of severe neonatal asphyxia in a group showing late neurologic signs and in which birth injury was excluded so far as possible. Schreiber [23] studied a group of five hundred neurologic patients and found that 70 per cent of those whose birth histories were available had a record of neonatal apnea.

The difficulty in correlating clinical studies of mental or neurologic defects with anoxemia at birth is similar to that with pathologic studies; that is, traumatic factors are constantly associated with delivery through the birth canal. It goes without saying that one can interpret neonatal apnea as being a manifestation of traumatic brain injury or developmental defect just as logically as to consider the apnea primarily responsible for the brain damage. This is important because we are interested in the effect of pure asphyxia with its relationship to obstetrical analgesia. The problem should be investigated in such a manner as to eliminate, as far as possible, the effects of birth trauma upon the head. Possibly this could be done by studying a selected group of infants delivered by cesarean section.

Nevertheless, the fact remains that anoxemia does injure cells and, regardless of the presence of associated circulatory changes and traumatic factors, asphyxia most exert an additional effect which may leave serious irreparable damage to the central nervous system.

METHODS OF RESUSCITATION

In order to consider logically what measures should be taken to resuscitate an asphyxiated newborn infant, it would be well to recapitulate the situation which exists under such circumstances. Assuming the fetus was normal and had reached a mature stage of development, something has happened to arrest the previously functioning respiratory mechanism. The infant is not breathing and obviously needs oxygen. It is suffering from a grave oxygen deficit, an increased CO_2 tension, and a progressing acidosis. The factors which may have operated to bring about this condition are, first, narcosis resulting from drugs administered to the mother; second, shock produced by the trauma of birth; third, anoxemia caused by the natural interruption of the placental circulation; fourth, a possible obstruction of the respiratory tract by mucus or meconium; and, perhaps, fifth, gross brain injury which intensifies the state of shock and may directly affect the nerve centers.

The first consideration in dealing with this situation is gentleness. Violent physical stimulation will only increase the degree of shock and aggravate or produce hemorrhage. Shock and hemorrhage are combated by gentleness and warmth. Cold baths, violent slapping, swinging or flexing the infant are unjustifiable. While maintaining the infant's temperature, oxygen should be administered. But before this can be done the respiratory passages must be cleared of obstructing mucus. This may sometimes be accomplished sufficiently by merely aspirating the nose, mouth and pharynx, but it may be wise not to delay long before aspirating the trachea. Tracheal aspiration is done by inserting a catheter either under direct visualization with the Flagg laryngoscope, or by guiding the catheter to the glottis with the index finger.[24] Either of these methods can be used effectively by one who has had practice, and there is little risk of trauma if the laryngeal reflexes are absent, as is the case when asphyxia is severe.[12]

Oxygen can then be administered by any of several methods. If the infant is making some respiratory efforts, and the air passages have been cleared, oxygen is certainly most safely administered by inhalation with a funnel, tent, or loose mask. However, if no respiration is present, it is necessary to try some mechanical means of ex-

panding the lungs. Theoretically, the ideal apparatus to use is the Drinker respirator, but in some clinics it has not proved satisfactory.[25,26]

Artificial respiration, carried out by compressing the thorax with the hand, may help in some of the milder types of asphyxia, but is probably futile in severe cases where tonus is almost entirely absent. It is, however, safe if done gently, and can be tried.

Mouth-to-mouth insufflation is dangerous because of the possibility of infection and overdistention of the alveoli. Usually, most of the air blown into the baby's mouth goes into the stomach, but, nevertheless, this method has been used many times with excellent results.

Other methods involve the use of intermittent positive pressure, or alternating positive and negative pressures applied to the respiratory tract, either with a close-fitting mask or through the tracheal catheter.[12,24] Several machines have been developed which employ this principle, but they are all essentially pulmotors with mechanical refinements designed to safeguard the lungs against excessive pressure. Normally, the negative pressure in the pleural space varies from minus 5 to minus 10 millimeters of mercury.[27] It would not seem dangerous to exert the same degree of positive pressure inside the bronchial tree. Although some authorities condemn the use of any type of pulmotor,[28] some of the modern machines are gaining acceptance and are reported to give good results without injuring the respiratory tract.[29,24] It is needless to say that such machines should be used only by those familiar with their construction, and that they should be constantly checked to insure their perfect working order.

The use of stimulating drugs for resuscitation is probably the most controversial aspect of this entire subject. When anoxemia has caused a certain degree of nerve-cell dysfunction, stimulatory drugs are without effect. However, it is difficult to define clinically the threshold of this change. Probably in instances where the element of narcosis predominates over that of anoxemia, certain drugs, such as alpha-lobelin or coramin, may be of some value. However, in such instances the simplest and safest stimulant to use is a whiff of ammonia applied on a piece of gauze held over the nostrils.

It must be remembered that it is difficult accurately to assess the value of any active method of resuscitating newborn infants, because there are no uniformly recognized criteria upon which to base their use. Probably, on many occasions, drugs or mechanical measures have been used unnecessarily and thus received undeserved credit.

Possibly, too, some controversy would be avoided and greater accuracy obtained if the principles of resuscitating a newborn infant are stated as follows:

Must be done:

1. Maintain warmth.
2. Be gentle.
3. Clear the respiratory passages.
4. Administer oxygen.

Must not be done:

1. Chilling.
2. Violent or rough manipulation.

May be used if the indications seem sufficient, and the potential harm is evaluated:

1. Stimulatory drugs.
2. Mouth-to-mouth insufflation.
3. Nonviolent cutaneous stimulation.
4. Mechanical respiratory measures.

SUMMARY

Respiration is normally initiated *in utero* only to be interrupted during the process of delivery. The resumption of respiratory activity depends upon several factors: shock, narcosis, obstruction to respiratory passages, and damage to the vital nerve centers by trauma or anoxemia.

The continuation of a state of anoxemia further injures vital nerve cells and may result in death or permanent residual defects of function.

The most urgent need is oxygen, but warmth and gentleness must be insured by any method of oxygen administration.

No method of resuscitation is completely satisfactory; each carrying its own potential dangers and certain inadequacies. Of greatest importance is the requirement that the physician be aware of these dangers and limitations, that he be familiar with several techniques, and that he understand the physiologic and pathologic circumstances involved in neonatal asphyxia.

490 Post Street.

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MEDICAL AID IN THE U. S. S. R. ARMY

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"MODERN warfare affects considerably our entire military medical service and especially our military surgery." This was the statement made by the Russian Professor Burdenko, the well-known surgeon and a member of the Academy of Science of the U. S. S. R. His statement is similar to those made in France and England, to the effect that there is no front line, such as existed in the first World War. The flexibility of the so-called front line of today must be met by flexibility on the part of the medical units in meeting any emergency.

In an article released for the press, Professor Burdenko relates that experience has proven the practical advantages of evacuating disabled soldiers into safer and distant areas, where the casualties can receive the treatment best suited for their needs in well equipped hospitals. For that reason the ambulance service is trained in the skill of expedient and speedy removal of wounded from the danger zone. The ambulances are specially constructed so as to afford maximum comfort in transportation in order to avoid any secondary shocks, etc. First aid in the battlefront is limited to proper dressing, preliminary surgical treatments and the application of preventive serum. In order to prevent infection of wounds, the affected tissue is excised within six to eighteen hours from the time the wound was inflicted. Burdenko reports that among 10,000 cases of wounded soldiers examined in medical institutions, he found only two cases of tetanus and a very few cases of gas gangrene. The efficiency of the medical service accounts for the fact that cases of complications are indeed very few in comparison with those of the last war.

In the recent report of Brigadier Kupriyanov, surgeon-in-chief at the front, we find that gas gangrene cases do not exceed 3 per cent, whereas formerly the mortality from this complication reached 75 per cent. In ten weeks of war, only six cases of tetanus were registered among the wounded. The care of infection is facilitated by the intelligence of the soldier, who has a good understanding of personal hygiene which also explains why instances of lice-infested clothing are rare. I am reminded that in the Russian Civil War following the first World War, practically all the military hospitals of Kharkov, the former capital of Ukraine, numbering over sixteen with a capacity of more than 5,000 beds, were filled with men afflicted mostly with lice-borne diseases, such as typhus and relapsing fevers. Illiteracy of the soldiers, poverty, filth, insufficient food, lack of vitamins and other unhygienic conditions, were factors that brought about prevailing epidemics. The casualty clearing center, located at the main railroad station in Kharkov, was filled with prostrated patients, many of whom died before reaching the hospital. It was compulsory to destroy all the uniforms infested with lice and the clothing actually burned explosively like firecrackers. The soldiers of the U. S. S. R. army of today receive well regulated diet. There is no more illiteracy. Personal hygiene, good clothing, footwear and moral status—all are factors that today augment the soldier's resistance to strain of war and possible infection.

Medical research in the U. S. S. R. at the present time is mostly limited to problems affecting the health and the fighting efficiency of the men at the front. Attention is also directed toward finding new safeguards against infection and new methods of rapid healing of the wounds. All the methods which have proven beneficial under laboratory conditions, have been introduced into routine practice. These include not only the treatment of wounds, but of emergency cases such as nervous and traumatic shocks, cardiac disturbances due to electric shock and the combat of fatigue due to sleepless nights.

Recently an institute of surgeon consultants has been introduced in the Red Army. These consultants are classified as the front, army and main unit surgeons. Members are selected from those highly skilled in surgery, mostly among professors of the medical schools. The aim of the institute is to supervise and to improve the work of the regular military surgeons. Most of the casualties occur as a result of air-bombing, hand grenades and trench mortar fire. The percentage of bullet wounds is comparatively small.

Burdenko originated the idea of having a well equipped surgical unit for the special treatment of brain wounds as near the battle zone as possible, because it was known that distance very often determined life or death in brain injuries.

In order to keep pace with the change of strategy from positional warfare to a war of maneuvers, the practice of establishing large hospitals at the front has been abandoned in favor of a system of mobile medical units.

Warfare of today as fought by master strategists and tacticians, guerilla warfare, pincer tactics, etc., challenge the medical authorities to search for new approaches to the problem of meeting emergencies. No doubt the difficulties could be lessened by introducing sound knowledge of first aid in army training, so that the average soldier should have at least an elementary understanding of nursing. He would thus be able to render help to his comrades in such emergencies as bleeding, electric shock, care of fractures or other contingencies.

450 Sutter Street.

TEACHING OF DERMATOLOGY: ITS DEVELOPMENT IN SAN FRANCISCO*

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WHEN I came to San Francisco in 1886 there were here three medical schools—the Toland, the Lane, and an Eclectic Medical School. This last, of very little account, was a reminder of a previous botanical enthusiasm, incited by the introduction of such drugs as the South American ipecac and cinchona.

FORMATION OF A MEDICAL SCHOOL IN THE LAST CENTURY

The formation of a medical school in those days was a simple matter. A group would gather about some prominent medical man, usually a surgeon, secure a building, deliver lectures, and issue degrees. In 1858, Elias S. Cooper had established such a school, which faded out on his death in 1862. In 1870 his nephew, Levi Cooper Lane, and Henry Gibbons reorganized it, calling it the Medical College of the Pacific. Also in 1862, the year that Elias Cooper died, H. H. Toland founded his school, and transferred it to the University of California in 1872. The University received it, but that was all it did.

In those days the universities in every English-speaking country regarded medical schools with indifference. It was in France and Germany and, to a lesser extent, in England that the modern medical schools really first began their careers as seats of learning and investigation, and established laboratories and well-appointed teaching clinics.

DEPARTMENTS

The number of chairs in the old-time school was limited to the essentials of anatomy, physiology, therapeutics, surgery, medicine, obstetrics and possibly chemistry, and all were mere lectureships, excepting anatomy. Almost the only expenses were for the building and the dissecting room, and with a good run of students there was a nice profit to divide among the few professors at the close of the term. In such a set-up there was little room for specialists on the faculty, and especially none for a dermatologist.

Both schools were summer schools. Because the entire faculty, including the anatomist, was composed of practitioners, it was an advantage to operate during the summer, when there was less sickness, and therefore more leisure for lecturing than during the more severe winter weather.

H. H. TOLAND AND BEVERLY COLE

Toland located his school away north on Stockton Street, near the County Hospital, but he had on his staff Beverly Cole, who had gastric trouble and a corresponding temper. Hence a quarrel arose, Cole resigned and went into politics, and for spite had the County Hospital removed from the neighborhood of the Toland School far out into a district called the Potrero—the cow pasture. The school, however, retained its position in the Hospital, and through this, and by sharing its rooms and its anatomical department with a dental school, continued to exist. Benjamin F. Swan, professor of diseases of children, delivered a few lectures on diseases of the skin.

The medical students, few in number, got quite an airing riding in the street-cars running between the school building and the distant hospital.

ESTABLISHMENT OF A CLINIC FOR DISEASES OF THE SKIN IN THE MEDICAL COLLEGE OF THE PACIFIC, CURRENTLY CALLED THE COOPER SCHOOL

In 1882, Lane, who through his practice and through real estate, had become a very rich man, presented a building to the faculty, ample for lectures, a hospital and a clinic. It was called the Cooper School in honor of his uncle, and the clinic, the Morse Clinic in honor of a Doctor Morse, the father of John F. Morse, who had become a brilliant surgeon, and who used to deliver a few lectures on diseases of the skin, principally on syphilis.

In 1882, a skin clinic—first of such to be established in San Francisco—was organized in the Medical College of the Pacific, under Alfred Regensburger.

Lane viewed laboratories with contempt. As a concession, however, he had a man named Wythe deliver some lectures on the microscope, a handy instrument with which to diagnose Bright's disease, but nothing more. As for the skin, it was something he had to go through in order to reach the more succulent viscera beneath. However, I do not wish to speak derogatively of Lane. He was an excellent, energetic surgeon of his day, with a fine enthusiasm for his profession. His views were those of the majority, although a little more definitely expressed.

AUTHOR'S TRAINING

Before coming to San Francisco, I had had a good training in histology under Ramsay Wright of the University of Toronto, who had been educated in England, where the universities were realizing the importance of the natural sciences and, coincidentally, medicine. Wright taught histology in the proper manner: "Here are a frog, some instruments, and a book (Huxley's). Find out of what that frog is composed." Subsequently, I studied pathology in Heidelberg under Arnold and Thoma, and histology in Meyer's laboratory.

Here I was, a young stranger in San Francisco, with a training in histology and pathology, and experience in skin diseases acquired in the great clinics of New York, Vienna, Paris, and London, striving to make my way in a community where my acquirements were not regarded very highly. I was decidedly out of luck. William Osler of Johns Hopkins, and Clinton Cushing, a surgeon on Lane's faculty, tried in vain to get me a position as pathologist in Lane's School. However, while I was waiting for a place or a practice the new learning was reaching San Francisco, far out on the Pacific Coast, and it was much farther away then than now.

A Doctor Mauser rigged a laboratory for the study of bacteria, and wished me as an associate.

* Read before the San Francisco County Medical Society, February 11, 1941.

An Englishman named Stallard, who was an enthusiastic student of the new learning, mentioned my training to W. F. McNutt, a prominent member of the Toland faculty, and through them a chair of pathology was created, and I was installed. It was interesting that neither Mauser nor Stallard was connected with either of the two schools.

INTERESTING EXPERIENCE

Shortly after I joined the faculty a dividend was declared. I opposed the motion strenuously. True, I needed the money personally, but I also required the equipment which it would have obtained, for what is pathology without a bench and a microscope? The situation was indeed desperate. We were a poor school with almost no resources, in competition with a rival manned according to the standards of that time, with a good faculty and furnished with a good hospital.

However, this also showed the attitude of the majority of our faculty toward the new medicine. They might acquire a pathologist, but were unwilling to spend money on useless laboratory equipment.

I did not then realize that the days of the proprietary medical school were numbered, and that the cost of a medical education would far outstrip the money paid in as fees, and that it would almost become obligatory for a medical school to attach itself to a university.

The result of my first lecture, on Friedlander's bacillus, was not encouraging. On that afternoon I was sitting in my office, when three of the class called on me. After the lecture a committee of the graduating class had been formed, and as a result these three had been sent to ask me to desist, as they said the type of information I was giving would endanger their ability to pass the examinations before the other members of the faculty. The next class, however, was enthusiastic in my favor, and many of them became prominent practitioners, not particularly from following my ministrations, but from pursuing the new trend of events.

BEGINNING OF THE SAN FRANCISCO POLYCLINIC

In the meantime, things were shaping themselves in another direction. Harry M. Sherman and I gathered together a number of young men under the title of The Friday Evening Club, which later, and quite naturally, became the San Francisco Polyclinic.

The Polyclinic was organized in 1888, and differed from the medical schools in being composed almost entirely of specialists, of whom we had the most prominent then in the city, such as J. D. Arnold on diseases of the throat, Alec Whittell on the eye, George Chismore on genito-urinary diseases, and Harry M. Sherman, the orthopedist of the Children's Hospital, then a small institution on Thirteenth Street. The position of skin diseases as a specialty was then ill-defined, both by the public and by the profession, but the Polyclinic gave me an opportunity to aid in defining it, and it subsequently gave many another man a like chance, such as Leo Newmark, the neurologist, and Jack Shiels, the internist. The schools afforded no such opportunity, as they were composed, as above shown, of practitioners who were either openly or silently opposed to specialism.

Of the men who had a training in dermatology in San Francisco at that time, there were only Martin Regensburger; his cousin, Alfred Regensburger; John F. Morse and myself; two of whom, Martin Regensburger and myself, happened to be in the Polyclinic.

Our first location was a very modest building on Golden Gate Avenue near Market Street, modest because of our lack of means. We had lots of talent, but no money.

Through Martin Regensburger's friendship with the de Young family, we became more well-to-do, as Mrs. de Young, a very energetic lady, adopted us as her favorite charity, and we were soon able to rent a larger building on the south side of Ellis Street.

This involved an amusing incident. The building belonged to a Mr. Randall, who had no mind to let his property for a dispensary. As, however, he and his brother owned Wakelee's Drug Store, then the largest in the city, and as we were a group of actively practicing physicians, he was forced to accede. His face, nevertheless, was that of a reluctant landlord.

As a decided accession to our teaching facilities, we soon obtained a service in the County Hospital. Shortly after this we built our own building on the north line of Ellis Street near Jones.

DEPARTURE OF THE DENTISTS FROM THE TOLAND HALL

While holding my position on dermatology in the Polyclinic, I still continued to teach pathology in the Toland School, but for lack of room in the school building I taught at my own home. This lack of space soon changed to a dreary vacuity, as the dentists decided to move to quarters of their own. We had then an almost empty building, in which the rooms sounded hollow to our footsteps. I, with a few others, determined to employ the space for clinics, and for a pathologic laboratory. The situation of the building, however, was not propitious for clinics, and Dr. J. M. Williamson, who was always enterprising, determined to move away out opposite the County Hospital. We instantly had a large and varied material, the overflow from the hospital, but the quarters were too narrow. Williamson then found an empty building on New Montgomery Street in the crowded, poor quarter of the city.

This building was old and run-down, but it was solidly built. The rooms were high-ceiled and the windows were large. Formerly prizefights had been held here, and these active gentlemen needed light to place their blows correctly. The airy rooms, the good light, the favorable situation, even the ancient appearance of the building, reminded one of the St. Louis in Paris and the Allgemeines Krankenhaus in Vienna. Add to this a plentiful and varied material, and what more would one want, for as the Germans say: "Überal kocht man mit Wasser" (Everywhere cooking is done with water)? Everything was pleasant and appropriate.

There was still another advantage in our location. On our way back to the office we passed the Grand Hotel bar, the finest in the city, run by an eccentric named Ed Fay. You all know what hard work it is to put through the patients in a popular clinic in the short time permitted. After such a stint it was a great alleviation to call at Ed Fay's institution on the way home.

Ed, both by natural inclination and through the peculiarities of his occupation, had become a thoroughgoing cynic, and of his way of thought the following is an example. The Bohemian Club, then located on the corner of Stockton and Post streets, required a bartender, and the members feeling that Ed, who employed about twenty, might be able to help them select one, sent him a delegation, when one of whom began thus: "Now, look here, Ed, what we want is a nice clean young fellow who knows how to mix all the drinks and who is perfectly honest." Ed, filled with the knowledge of the wily ways of bartenders, looked up and replied: "You fellows don't want nothing, do ye?"

We had a good staff of young men, all working in harmony, and a good clinical laboratory under the management of Doctor Ryfkogel, whom I, myself, had trained. I would gladly have remained there, but events decided otherwise.

INTERESTING CASES

Here I may mention an achievement of the laboratory. I had as assistant a delightful fellow, W. G. Hay, and I repeatedly drew his attention to yellow dots in the cheek pouches, saying I was sure, from their appearance, that they were sebaceous glands. It was about the time Fordyce had described similar spots in the mucous membrane of the lips, to which the name Fordyce's disease still clings. Finally we managed to cut a piece out of the cheek pouch of a patient, and Hay's enthusiasm was unbounded when the slides showed positive.

I, also in the clinic by a happy chance, ran across a case of that interesting disease, coccidioides. I soon learned that Emmet Rixford, a young surgeon in Lane's School, had already encountered a similar case, which he reported in association with Gilchrist of Johns Hopkins. Later, still, a talented woman, Rachel L. Ash, connected with our school, noted that a fungous growth appeared on cultures. This fungus she injected into guinea pigs and reproduced the disease. I had also noted this fungus but, thinking it a penicillium, threw it away.

In 1894 my work in the Polyclinic, in the University Clinic, and a growing practice caused me to ask the Toland faculty to allow me to resign the chair of pathology, and to appoint John C. Spencer in my place, and at the same time I requested them to create a chair of dermatology and to appoint me as professor. The Faculty graciously acceded. I then resigned from the Polyclinic.

UNIVERSITY OF CALIFORNIA MEDICAL SCHOOL

Beverly Cole, whom I have mentioned before, began to agitate for a medical building, this time to outdo Lane. In this particular line he was clever, and in his endeavor interested the dentists, not leaving out the pharmacists, all of whose departments were loosely attached to the University of California. He succeeded in getting money from the Legislature for the buildings, but none for land on which to build them. Finally this was granted us by Adolph Sutro, six and a half acres of it, commanding a wonderful view of the city, but away out in the country. Later, through Mrs. Phoebe Hearst, we secured an anatomist and a pathologist. It began to look like a modern medical school, but the clinic stayed down town, and so did the clinical laboratory.

THE FIRE OF 1906

One morning, in 1906, I was lying awake thinking of what I should say in the clinical lecture to be delivered that day, when the bed shook and a low, deep rumble was heard, then another rumble and shake, harder and deeper, and the bed shook more decidedly, and I turned over, fearing the plaster from the ceiling might fall in my face. Then came a fierce jolt upward, causing the bed to bounce, and me with it, and then an equally ominous silence. I arose and went to the window, and saw many bricks on the street. I returned to bed. I knew that no clinic would be held that day, but I did not realize that fires had been started which would shortly burn out my home, my library, my clinic, the cherished laboratory and all my records.

The morning of the second day I realized that my residence was in danger. The only vehicles attainable were a baby carriage and a child's toy wagon. We put our invalid daughter in the baby carriage and some bedding in the toy wagon, and the family set out for Twin Peaks, south of the city. That night we slept in the open, and soundly, and the following morning was glorious. I realized, as never before, how correct the Greeks were in giving their gods calm, beautiful faces; for, after rendering us destitute, Nature resumed her calm, even way as if nothing had happened.

After the earthquake, Harry M. Sherman, one of our surgeons, worked hard to assemble a much-distracted faculty. He quickly called a meeting at his home, which was intact. He turned the rooms of our building not used for teaching into a hospital and, taking advantage of the natural charitableness excited by such a calamity, succeeded in securing the necessary furnishings.

In 1911, Howard Morrow, who had long been connected with the Clinic, and who already, in 1908, had been appointed assistant professor, was made full professor. Furthermore, through the Wassermann reaction the dermatological laboratory had acquired a new and important position, and it was put in charge of Lionel Schmidt.

THE CHAIR OF CLINICAL DERMATOLOGY IN STANFORD UNIVERSITY

Under David Friedlander, in 1903, a special department on dermatology was instituted in the Cooper Medical College. As before mentioned, a skin disease clinic had been previously organized under Alfred Regensburger, but had lapsed.

In 1908 the Cooper Medical School, following the usual trend of the proprietary ones, became the medical department of Stanford University.

Dr. Harry E. Alderson was graduated in medicine from the University of California and, after further study in this country and abroad, joined our clinic, where his good work, and especially a paper he wrote on the pathologic anatomy of lichen planus, secured him recognition from Prof. George T. Jackson of Columbia University, and hence that of President Wilbur of Stanford, who in 1908 appointed him clinical professor of dermatology. Under his astute management the Clinic has become well manned, well equipped, and provided with abundant and varied material.

INTRODUCTION OF RADIANT ENERGY

Sherman, in his enthusiastic reconstruction of the hospital after the fire, touched me for a nice sum, which he wished to devote to window screens, but which I insisted should be employed in rigging up the cutaneous clinic, especially with an x-ray apparatus, which was then enjoying the vogue of a new therapeutic instrument. This I imported from France, and it was similar to one I had in my office. Fortunately, they were worthless instruments, as the plunger which made the interruptions was much too slow to get an effective current. I say fortunately, because the enthusiasm awakened by the new treatment was boundless, and many of the operators were burned, one of whom, a woman, died of her injuries.

At about the same period radium was introduced, and M. Curie, himself, got a burn of the thigh through carrying it in his pocket while traveling from Paris to London. Radium did less damage than the x-rays, principally because it was so dear that it was less employed. I, luckily, was associated with George D. Culver, one of the cleverest clinicians I have ever known, who devised a technique safe both for the patient and the operator.

INTRODUCTION OF SALVARSAN

The next acquisition for dermatology was salvarsan, which I first heard mentioned by Bartolomeo Sommer while in Buenos Aires in 1910. Because of this I went to Europe, and while in Paris saw some of the terrible ulcers of the buttocks caused by the new remedy. In Frankfort, Professor Ehrlich advised me to see it given by infusion, and I marvelled at the temerity of both patient and doctor at infusing at one dose fifty times the lethal quantity of arsenic. Still another marvel was the speed with which it cleared up the lesions of the skin and mucous membranes. After visiting the Magdeburg Clinic, where Arl and Schreiber first introduced the drug by infusion, I was presented with a box of ampoules, which I forwarded to the University of California Clinic. This must have been among the very first used in America.

Salvarsan caused two revolutions in the practice of medicine. It introduced intravenous medication, now so popular, and it caused syphilis to be regarded, as it should be, as a disease for the internist.

STUDY OF VITAMINS AND ALLERGY

Through the Wassermann reaction in diagnosis, and the arsenicals and bismuth in treatment, syphilis, as above mentioned, became a disease for the internist, and dermatologists turned more definitely to the study of the other dermatoses, particularly to allergy and the influence of the vitamins. Harry Templeton, of the University Clinic in Berkeley, has, with his usual energy, employed his material in developing our knowledge of the vitamins, and Albert H. Rowe is a well-known authority on allergy.

During the years we have reviewed, the practice of medicine has made many notable changes, and those connected with dermatology, besides its gradual recognition as a specialty, are the discovery of the Wassermann reaction of the blood in syphilis, the introduction of intravenous medication and the especial aptitude of the skin for showing the vitamin deficiencies and the allergic reactions. The skin is a supremely sensitive organ, and many of its sensations are easily demonstrable, such as touch, locality, pain, heat, and cold. There are besides, however, many other sensations and functions not so easily elicited, and it would appear that the future scientific advance of this study lies in the neurodermatoses, as indicated in the recent book by Becker and Obermayer.[1]

In concluding, my desire is that the study of this specialty, which has advanced so far, may continue to be ever more fruitful in beneficent results, both to physician and patient.

450 Sutter Street.

REFERENCE

1. Becker, S. William, and Obermayer, Maximilian E.: Modern Dermatology. J. B. Lippincott Company, Philadelphia, 1940.

CLINICAL NOTES AND CASE REPORTS

HIPPOCRATES' APHORISMS*

By Moses Scholtz, M. D.
Arcadia

Section Seven (Continued)

37. Hemoptysis without fever
Is curable, but brings
Death when joint with fever; treat it
With cold and styptic things.

38. A serous effusion
In the pleura displays
Suppuration,
In twenty days.

39. Identical with iv-80.

40. Paralysis of the tongue
Or other body-parts,
From melancholic humors
Mostly starts.

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* For other aphorisms, see California and Western Medicine, March 1940, page 125; April 1940, page 179; May 1940, page 231; July 1940, page 35; August 1940, page 85; September 1940, page 130; December 1940, page 272; January 1941, page 27; February 1941, page 82; March 1941, page 124; April 1941, page 229; July 1941, page 35; September 1941, page 140; October 1941, page 204; November, 1941, page 254.

41. If strong catharsis is followed
By hiccups in old folk,
Around the sick
Grave dangers stalk.

42. Fevers not of bilious nature
Can be helped or cured,
If effusions of hot water
On the head can be secured.

43. Obeying Nature's
Strange commands,
Women don't have equal
Use of both hands.

44. When in empyema dealt with cautery or knife
Pure white pus meets the healer's eye,
The sick will live; but if pus's bloody,
Slimy, fetid, the sick will die.

45. The sick gets well with liver abscess,
Opened by cautery or knife,
If pus is pure and white; but if it looks
Like dregs of oil, the sick will lose his life.

46. By drinking undiluted wine,
One can relieve pain of the eyes;
Also by copious hot baths,
Or, if one venesection tries.

47. Dropsy, followed
By a hiccup-spell,
Rings for the sick
His death-knell.

48. Dysuria is cured
By drinking pure wine,
And by venesection
On the inside line.

49. Identical with vi-37.

50. If brain is stricken with gangrene,
The sick dies in three days;
But, if he does survive this term,
Restored to health, he stays.

51. Sneezing comes from heat and moisture
In the cavities of the head;
The excess air, expelled, resounds
Through narrow passages, being sped.

52. A fever, supervening
On painful liver maladies,
Causes the pain
Soon to decrease.

53. Identical with vi-47.

54. Undrained, phlegm between the stomach
And diaphragm occasions pains,
But it clears up by being diverted
To the bladder, through the veins.

55. A liver filled with water
Which bursts into the cavity
Of the abdomen, fills it,
And leads to the fatality.

56. One can relieve
Chills, yawning and anxiety
By drinking wine and water,
Mixed evenly.

57. Identical with iv-35.

58. In strong concussions
Of the brain,
The sick the loss
Of speech sustain.

59. Identical with iv-35.

60. For men of humid flesh
Fasting is good,
Because it has
A drying aptitude.

61. Identical with iv-40.

62. Copious sweats, be hot or cold,
In a constant stream, mean humid flesh;
It calls for purging downward
In the weak, and in the strong upward.

63. Identical with iv-43.

64. Identical with iv-44.

65. Identical with iv-45.

66. A food, which brings strength to a well person
And is borne well by him with ease,
If given to a fevered sick,
Turns poison and spurs on disease.

67. If the urine
Appears right,
The patient's outlook
Is bright.

68. When feces, if allowed to stand unshaken,
Display a sediment of bowels-shreds,
Strong purge is good; but giving food before it
Is wrong, as from it danger spreads.

69. Black bile is commonly
The source of crude feces,
And regulates its growth,
Its losses and increases.

70. Identical with iv-47.

71. Before commencing purging, prepare the body
For it: for cleansing upward
The belly should be bound, but moistened
For cleansing downward.

72. Identical with ii-3.

73. Identical with iv-48.

74. Identical with iv-49.

75. Dropsy oft trails anasarca.

76. Identical with vii-6.

77. Identical with vi-43.

78. Gangrene is prone
To cause sequestre of the bone.

79-80. Identical with vii-15, 16.

81. If body-fluids and the skin
Are changed, disease is marked thereby;
And, when the changes are extreme,
The sick are apt to fail and die.

82. When people over forty turn maniacs,
They do not easily get well;
But when disease fits age and constitution,
A brighter course can one foretell.

83. Identical with iv-52.

84. When in quartan fevers
A nose-bleed takes place,
Many new dangers
The sick will face.

85. Sweats strong, quick, copious and cold
Are bad, when not on crisis-days,
For they arise from violence of pain,
And long duration of the case.

86. Excessive diarrheas
Are bad in long disease.

87. Diseases that resist all drugs
May finally yield to knife,
And others still may yield to fire;
The rest will plague the sick for life.

413 Longden Avenue.

(The End)

MEDICAL EPONYMS

Klebs-Loeffler Bacillus

The bacillus of diphtheria was discovered by Edwin Klebs (1834-1913), of Zürich, and reported at the Second Congress for Internal Medicine at Wiesbaden on April 19, 1883. The paper "Ueber Diphtherie [On Diphtheria]" is printed in the *Verhandlungen des Kongresses für innere Medizin* (2:139-154, 1883). A portion of the translation follows:

"In form, these rods are of equal length, quite narrow and, on the whole, hardly as large as tubercle bacilli. A fair number are spore bearers, each rod always having two spores, one at each end."

Friedrich August Johann Loeffler (1852-1915), in a monograph entitled "Untersuchungen über die Bedeutung der Mikroörganismen für die Entstehung der Diphtherie beim Menchen, bei der Taube und beim Kalbe [Studies concerning the Significance of Microörganisms in the Etiology of Diphtheria in the Human Being, in the Pigeon, and in the Calf]," was able to demonstrate by the application of Koch's postulates that the organism described by Klebs was indeed the etiologic factor in diphtheria. In this monograph, which was published in the *Mitteilungen aus dem kaiserlichen Gesundheitsamte* (2:421-499, 1884), the author refers to previous investigations. A portion of the translation follows:

"We thus see that studies dealing with the significance of bacteria that occur in diphtheritic material have not as yet led to any satisfactory conclusions. It seemed imperative, therefore, to attack the solution of this important question with the help of the newest investigative methods, namely Koch's methods of culture on solid media, and thus to discover the significance of all these kinds of bacteria. It was necessary, first, to determine which varieties, by reason of their relation to the diseased tissues, seem to be chiefly concerned in the etiology of diphtheria, then to grow these in pure culture, and finally to undertake animal inoculation experiments with the pure cultures in as many species as possible."

There follows a detailed account of the successful investigation that enabled him to say in conclusion: "We thus have here two examples of perfect, infectious diphtheria of pure bacillary origin."—R. W. B., in *New England Journal of Medicine,* Vol. 225, No. 14.

Koch's Postulates

These postulates are laid down in the monumental contribution of Robert Koch (1843-1910), "Die Aetiologie der Tuberculose (The Etiology of Tuberculosis)," which was delivered as a lecture to the Physiological Society in Berlin on March 24, 1882. It appears in the *Berliner klinische Wochenschrift* (19:221-230, 1882). A portion of the translation follows:

"To prove that tuberculosis is a parasitic disease occasioned by the invasion of the bacilli and primarily caused by their growth and increase, these bacilli had to be isolated from the body, and kept in pure culture until they were free from any possible contamination with other disease products of the animal organism; and finally it was necessary to reproduce the same disease picture of tuberculosis (which experience showed could be obtained by injection of naturally produced tuberculous material) by transfer of the isolated bacilli into animals."

Koch then described his method of staining the tubercle bacilli, finding them in the lesions and culturing them. His success in reproducing tuberculous lesions and recovering the bacilli from them established a standard for this type of bacterial investigation that has remained fixed ever since.—R. W. B., in *New England Journal of Medicine,* Vol. 225, No. 15.

Horner's Syndrome

Johann Friedrich Horner (1831-1886), professor at Zurich, published an article "Ueber eine Form von Ptosis [Concerning a Form of Ptosis]" in the *Klinische Monatsblätter für Augenheilkunde* (7:193-198, 1869). A portion of the translation follows:

"Six weeks after the last pregnancy that occurred a year before I saw her, the patient noticed a gradual drooping of the right upper eyelid . . . the pupil of the right eye was found to be definitely smaller than that of the left, the eyeball very slightly sunken. . . . While the case was under observation, there developed before our eyes gradually increasing redness and heat of the right half of the face, although the left half remained pale and cold. . . . The patient then told us for the first time that she had never perspired on the right side. . . . I believe that in view of all these symptoms no one will question my opinion that this gradually developing, but never complete, ptosis should be regarded as a paralysis of the superior palpebral muscle, which is supplied by the sympathetic. I thus regard the phenomenon in the upper lid as a part of a larger symptom-complex.—R. W. B., in *New England Journal of Medicine,* Vol. 224, No. 24.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

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CALIFORNIA COMMITTEE ON MEDICAL PREPAREDNESS†

The Physician and Selective Service*

. . . The question is, What is our job in Selective Service? It is procurement of man power—the registration, classification and examination leading to the induction within the next five years of 4,400,000 men for service with the Army. It is the classification of facts relative to approximately 16,500,000 registrants which should reveal a cross-section of the social and economic status and the health of the younger men of the country. From this group we are to examine, physically, mentally and morally, about 6,600,000 and, if fortunate, turn over to the Army 4,400,000 in the course of five years. What is our *modus operandi?* We operate through local boards. Examining physicians determine the physical fitness of registrants, assisted by medical advisory boards made up of ten physicians. In the event of dissatisfaction, appeal is made to an appeal board, and medicine is also represented on this board. This system of local boards throughout the country is decentralized and directed from state headquarters. National headquarters in Washington, D. C., is concerned chiefly with matters of guidance, policy, and administration. What is our most effective working unit? The local board really does the work, makes the decisions and sends the men to the Army. These number about 6,400 with some 18,000 examining physicians, all of whom are functioning on a voluntary basis and without pay. . . .

* * *

Priorities in Spending

. . . We are hearing a great deal, and necessarily so, of priorities. That is to say, certain kinds of things are held to be more essential than other things which are desirable but not indispensable. Those items which are

† Harold A. Fletcher, M. D., 490 Post Street, San Francisco, is the chairman of the California Committee on Medical Preparedness. Charles A. Dukes, M. D., 426 Seventeenth Street, Oakland, is a member of the American Medical Association Committee on Medical Preparedness. Roster of county chairmen on Medical Preparedness appeared in CALIFORNIA AND WESTERN MEDICINE, August, 1940, on page 86.

* From an address by Col. Leonard G. Rowntree, M. D., Chief of the Medical Division, Selective Service System, Washington, D. C.

Presented at the Thirty-Seventh Annual Congress on Medical Education and Licensure, Chicago, February 17, 1941.

given priority must be produced and distributed whether other goods, which are equally desirable or even more useful in normal times, are available or not. For example, we are all aware of the drive to collect aluminum and of the severe restrictions upon the use of aluminum in manufacture, except for defense purposes. That is only the most widely advertised instance, but it is typical of many, many others not so well publicized. Everyone recognizes that a system of priorities is essential, that it is inescapable and that it would be a great mistake to try to get along without it. . . .

* * *

The above comments are of interest in connection with a letter received from Edwin L. Bruck, M. D., of San Francisco. The attention of the American Medical Association was called thereto, and in the minutes of a trustees' meeting (*The Journal of the American Medical Association*, November 22, page 1808) note is made that the subject of "Priorities" was given consideration. Doctor Bruck's letter follows:

(COPY)

Dear Doctor Kress:

Enclosed you will find a copy of "Chapter LX. Office of Production Management, subchapter B—Priorities Division. Part 958, Repairs, maintenance, and supplies. Preference Rating Order P-22, Amended."

You will notice that, by definition, a producer, as defined by this group of rules, does not include in it any place, anyone who might practice medicine as a private practitioner—or anyone maintaining the health of the general public, who would be paying for the maintenance of their general health.

We are not able to find any place in this rule, evidence that a private practitioner may be able to purchase necessary supplies for laboratory work, and at the present time Braun, Knecht and Heimann of San Francisco, from whom we buy our laboratory supplies, have told us that it would be impossible in the future to obtain such supplies unless we were able to show evidence of priority certificate of some sort.

You will note that in Section E, No. 1, "Application of Preference Rating," that we have outlined that which is necessary to accompany all orders to purchase the smallest laboratory supply. And in this we would be subject to penalty, as outlined in Section J. were it not for the fact that we were ordering materials for maintenance, repair, or operating supplies.

It seems to me that there should be from the Office of Production Management in Washington, inclusion in the rules and regulations of practitioners of private medicine, as well as all the other individuals rated as producers.

It also seems to me that maintenance of the public health by any means including the private practice of medicine which of course takes care of the greater part of the public health—and as incomes increase will take care of more and more of the public health—that those individuals practicing in this fashion should have at least the same preference rating and the same ability to purchase necessary laboratory and office supplies, as clinics, hospitals, charitable institutions, educational institutions, sanatoriums—public, private, or combined; and that such provision should be made so that all would fall into the same category, and that all of us be allowed to purchase these supplies legally and without question of doubt.

Very truly yours,

(Signed) EDWIN L. BRUCK, M. D.

* * *

Office of Civilian Defense
Washington, D. C.

October 27, 1941.

Medical Division Memorandum No. 1*

Subject: Advanced First Aid for Civilian Defense

The United States Director of Civilian Defense has urged all communities to spread knowledge of first aid as widely as possible among the people. Competent instructors qualified by the American Red Cross are required for training Civilian Defense workers, employees of industrial plants, business establishments and Government bureaus. For this purpose, physicians should register as instructors with the local Red Cross Chapter and should employ the "Instructor's Outline" for the standard course (twenty hours), prepared by the American National Red Cross in collaboration with the Medical Division of the Office of Civilian Defense and published by the American Red Cross. Upon completion of this course, participants will be entitled to receive the First Aid Certificate of the Red Cross and be authorized to wear the appropriate insignia.

Copies of "Advanced First Aid for Civilian Defense" are obtainable for free distribution by application to the Regional Director or Regional Medical Officer in your Civilian Defense region. For copies of the "Instructor's Outline" (twenty-hour course), applications should be addressed to the local Red Cross Chapter.

GEORGE BAEHR, M. D.,
Chief Medical Officer.

* * *

Health Education Consultants to Be Assigned to Key Defense Areas

A vital part of this nation's "all out" defense effort is the safeguarding of its health. The rapid growth in industrial and governmental production has caused unusual concentrations of population and increasing health problems. To assist state, county, and local health officials in coping with these problems, the United States Public Health Service is planning to appoint health education consultants to various defense areas. The positions, paying $2,600 to $3,800 a year, will be filled through the open competitive examination process and the Federal Civil Service Commission has just issued the examination announcement. A written test will not be given, but applicants will be rated on their qualifications as shown in their applications and corroborative evidence. . . .

Applications must be filed with the Civil Service Commission in Washington, D. C., not later than December 11, 1941. The examination announcement giving detailed requirements can be consulted or obtained at any first- or second-class post office or at the central office in Washington, D. C.

* * *

No Mass-Production Doctors

No group is working harder for American defense than private medicine. Doctors by the thousands have entered the military services. Selectees for our great new army are examined by local doctors who receive no payments whatsoever. The American Medical Association has pledged its fullest coöperation, and its members are fulfilling that pledge.

However, out of justice to the public, the medical fraternity must oppose proposals which it believes would have a dangerous effect on the national health. In a recent editorial, *The Journal of the American Medical Association* says, "It should not be necessary to argue that a continuing and undiminished supply of well-trained physicians is absolutely essential to the welfare of the nation. We cannot speed up that training beyond a certain point without lowering educational standards and degrading the quality of medical service. The present crisis demands, in fact, better qualified physicians if we are to face the future with reasonable confidence."

Doctors cannot be turned out like machines, on a mass-production basis. To substantially reduce the length of time given to medical training would have far-reaching effects on the public health in the future. This country has the finest physicians in the world—and the main reason is that it has the finest schools of medicine. Unless the strictest standards of medical training continue to prevail, the health of this nation cannot help but suffer severely.—San Mateo *Times and Leader*, October 17.

* * *

Some Facts About the Enemy

It is plain truth that syphilis and gonorrhea are among the gravest dangers which threaten national health and strength. Syphilis alone has caused more deaths than all the wars in history, more suffering than all the wounds of battle. Like war, it cuts men off in their prime. Like modern warfare, it does not spare women and children. No one knows how to measure the harm done by gonorrhea. Several times more prevalent than syphilis, it cripples limbs, prevents parenthood, blinds babies.

Both these diseases are chief causes of sick report and disability in the Army and Navy. They rank high among

* For Bulletin, see *The Journal of the American Medical Association*, August 30, 1941, on page 793.

the reasons for failure of 50 per cent of Selective Service candidates to pass the physical examinations given by local Draft Boards and Army physicians. In industry they cause loss of time and hamper efficiency—keep workers and machines idle, or cause costly accidents and errors.

Medical reports show that syphilis and gonorrhea are nearly always acquired through sexual contact—and more often commercialized prostitutes than from any other source.

* * *

Estimated Dental Care Needed by Draft Rejectees

To make eligible for selective service 188,000 young men rejected for dental deficiencies, some 700,000 hours' work by dentists would be necessary.

This was estimated by Dr. Willard C. Fleming, dean of the University of California's College of Dentistry, who said that much dental time would be required if the Government carried out suggestions to rehabilitate young men rejected for selective service.

Dean Fleming pointed out that this would mean that an average of about three and a half hours would be spent on each man by a dentist. He emphasized that this would be the minimum of time which would be needed to equip men to fill minimum requirements of selective service. To give them adequate dental care would require a great deal more work, Doctor Fleming said.

Twenty per cent of the men rejected for selective service were rejected for dental deficiencies. Dean Fleming said that most of these men probably could meet requirements with some dental care.

* * *

Rehabilitation Spread Urged

Brigadier-General J. O. Donovan, State Director of Selective Service, said recently he believed and hoped that an announced plan for remedial dental work for rejected selective service registrants would be extended to include treatment for other physical defects causing rejection, according to a United Press dispatch from Sacramento.

General Donovan said that approximately 50 per cent of California registrants so far have been rejected for physical reasons. Of these, he said, about 60 per cent had defects which could be remedied.

He said he had advanced a plan whereby the selective service office would take over SRA camps in California to which rejected men could be admitted voluntarily for physical rehabilitation. He said he believed federal funds could be obtained for maintenance if the State Department of Finance approved use of the camps.

General Donovan added that President Roosevelt had been so enthusiastic about rehabilitation that he was sure a complete program would be worked out.

* * *

San Francisco Bay Area to Have Draft Test Center

Medical examination centers for draft registrants will be set up in thirteen California cities under a new selective service system designed to cut down on Army rejections of selectees.

Brigadier-General J. O. Donovan, Director of Selective Service, said Army examiners would combine former primary and final physical examinations at the centers, minimizing the possibility of a selectee who had passed his draft board test being turned down by the Army after he had severed civilian ties.

Permanent centers are to be established at San Francisco and Los Angeles. Temporary centers will be established at Sacramento, Fresno, Redding, Marysville, Stockton, Santa Rosa, San Jose, Bakersfield, Santa Barbara, San Bernardino, and San Diego.

Army officials have complained that under the old double examination system, rejections of selectees approved by local boards have been running as high as 11 per cent. Donovan said many rejectees had disposed of their businesses or resigned from their jobs, expecting to be inducted into the Army.

Under the new system, Donovan explained, if registrants pass the Army test, Class 1-A selectees will he called to report directly to reception centers within sixty days. The induction station procedure would be eliminated.

Civilian medical boards will continue to operate in the sparsely populated areas, Donovan said.

The new examination system was worked out by national headquarters of the selective service. Donovan said it would be established in other states of the Ninth Corps area—Oregon, Washington, Idaho, and Nevada—if it worked satisfactorily in California.

Draftees in Better Condition Than Men of 1917

Dr. Morris Fishbein declared recently that men of military age now are in better physical condition than those of similar age in 1917.

The editor of *The Journal of the American Medical Association* said that, despite opinions to the contrary, there has been a constant improvement in the health of Americans.

"The majority of evidence now available seems to establish certainly that the men now being inducted into our army are of an exceedingly high grade of physical fitness," he said.

Doctor Fishbein said that although there has been a much more rigid examination and higher standards, the rejection rate is approximately the same as in 1917.

His conclusions, published in *Hygeia*, along with a report of Lieutenant-Colonel Amos R. Koontz, Medical Director of the Maryland Selective Service System, showed:

The average stature of men is greater now than in 1917, suggesting adequate nutrition.

Army rejections for tuberculosis were about one-third of what they were in the World War.

There have been fewer cases of virtually all diseases in army camps.

COMMITTEE ON PUBLIC POLICY AND LEGISLATION†

Concerning Error in Article in "Journal of the American Medical Association"—Re: Émigré Physicians

The Journal of the American Medical Association, in its issue of November 29, 1941 (p. 1881) prints a seven-page article, "The Émigré Physician in America, 1941."

On page 1887, left column, seventh paragraph, appears this statement:

"A bill was recently passed in California which would deny the license even to a California native son who happens to he a graduate of a foreign school, unless the country in which the school is located extends reciprocity to Americans. This would bar the foreign-educated competent citizen physician, native or foreign-born, from California forever. This is, indeed, chauvinistic legislation of the most deplorable type. How it can be construed to be in the interests of the public welfare is difficult to see."

To keep the record correct, the attention of the sponsors of the article is called to the exact language of the new law (Chapter 751 to amend Section 2193 of the Business and Professions Code of California).

Perusal of the following shows that *The Journal of the American Medical Association* article is in error. *The law does not apply to citizens of California* who received their degrees abroad.

Excerpt follows:

CALIFORNIA ASSEMBLY BILL 1475 (NOW CHAPTER 751)

An act to amend Section 2193 of the Business and Professions Code, relating to applications for a physician's and surgeon's certificate by graduates of foreign medical schools.

The people of the State of California do enact as follows:

Section 1. Section 2193 of the Business and Professions Code is hereby amended to read as follows:

2193. An applicant, whose application is based on a diploma issued to him by a foreign medical school approved by the Board, except a Canadian school, shall furnish documentary evidence, satisfactory to the Board, that: . . .

. . . (*e*) If the applicant is not a citizen of the United States, the country in which he has been licensed to practice medicine and surgery will admit to practice therein citizens of the United States upon proof of prior admission to practice medicine and surgery in some state of the United States or upon proof of matters similar to those required in this section for graduates of foreign medical schools.

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† Component County Societies and California Medical Association members should not give endorsements to proposed legislation unless the California Medical Association Committee on Public Policy and Legislation has so requested. On such matters, address: California Medical Association Committee on Legislation, Dwight Murray, M. D., Chairman, 450 Sutter, San Francisco. Telephone, DOuglas 0062.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

San Bernardino County Medical Society: Two-Day Postgraduate Conference

A two-day postgraduate conference was held at the San Bernardino County Hospital on December 11 and 12. The program consisted of pediatric clinics.

* * *

Orange County Medical Society: Postgraduate Conference

On December 10, a clinical session was held in the Orange County Hospital in the morning, commencing at 10 a. m., and in the evening pediatric clinics were carried on at the St. Joseph Hospital.

* * *

Imperial County Medical Society: Refresher Course

A refresher course was held at El Centro on December 9, under the auspices of the Imperial County Medical Society. The program consisted of a series of pediatric clinics.

* * *

University of California Medical School Starts Cyclotron Course

To stimulate the application of one of medicine's newest and most important "set of tools," the department of medicine of the University of California Medical School has instituted an open course on the atom-smashing cyclotron and its products.

The course is probably the first of its kind ever given for a large group of medical men. Instructors are members of the staff of the University of California Radiation Laboratory in Berkeley. The cyclotron was invented by Professor E. O. Lawrence, Nobel Prize winner and head of the laboratory.

Institution of the course is a recognition that the use of the cyclotron and its products have definitely proved their worth and are ready for general use in biology and medicine.

Development of the cyclotron in medical and biological research has been under the direction of Dr. John H. Lawrence, assistant professor of medicine in the Medical School and brother of the inventor. The University of California has been the leader in this research, and its 225-ton atom-smasher, the most powerful in the world, is called the Medical Cyclotron.

The cyclotron produces radioactive elements, which give off rays somewhat as radium does. These rays make it possible to trace the elements in the body. Since the elements take part in life processes, these heretofore mysterious processes can be carefully studied. The cyclotron and radioactive elements have also been found useful in the treatment of certain types of tumors and diseases of the blood.

* * *

University of California Postgraduate Course

The University of California Medical School, Medical Center, San Francisco, on January 5 to 7, 1942, will conduct a postgraduate session for doctors of medicine in general practice on Clinical Aspects of New Therapy.

The course will be in charge of Stacy R. Mettier, M. D., Associate Professor of Medicine. Tuition fee: $20.

Registration: Physicians may register by mail. Please send checks (payable to the Regents of the University of California) to the Dean's Office, University of California Medical School, Medical Center, San Francisco. In order that arrangements may be made, it is desirable that all checks be received by the Dean's Office not later than January 2, 1942. Any physician who is unable to register by mail before that date is requested to register and pay his fee at the Dean's Office of the Medical School, Room 145, Clinics Building, The Medical Center, San Francisco, between 8:30 and 9 a. m. on January 5, 1942.

This short comprehensive course is designed to meet the needs of physicians engaged in private practice. Many of the discussions will be illustrated by patients, lantern slides or other material.

Physicians enrolled in the course will be welcome to use the facilities of the Medical School Library.

Program follows:

Monday, January 5, 1942

Symposium on Chemotherapy

Sulfonamide Drugs

9:00 a. m.—Chauncey D. Leake, Ph. D.—Pharmacological Aspects of the Sulfonamides.
9:30 a. m.—John W. Brown, M. D.—The Use of Sulfonamide Drugs in the Treatment of Pneumonia.
10:00 a. m.—Lewis F. Morrison, M. D.—Sulfonamide Drugs in the Treatment of Ear, Nose, and Throat Conditions.
10:30 a. m.—H. Glenn Bell, M. D.—Use of Sulfonamide Drugs in Surgical Conditions.
11:00 a. m.—Clark M. Johnson, M. D.—The Use and Abuse of Sulfonamide Drugs in Genito-Urinary Infections.
11:30 a. m.—Edwin L. Bruck, M. D.—Abnormal Reactions in the Use of Sulfonamide Drugs.

Symposium on Drugs Used on Central Nervous System

1:30 p. m.—Hubert R. Hathaway, M. D.—The Effects of Sedative and Pain-Relieving Drugs on the Respiratory System.
2:00 p. m.—Paul A. Gliebe, M. D.—Drugs of Value in Psychiatry.
2:45 p. m.—Douglas M. Kelley, M. D.—Therapy of Mental Illness by Shock Treatments (Insulin, Metrazol, Electric Shock).
3:45 p. m.—Chauncey D. Leake, Ph. D.—Drugs Affecting the Autonomic Nervous System.

Tuesday, January 6, 1942

Endocrine Therapy

9:00 a. m.—Evelyn Anderson Haymaker, M. D.—Organotherapy in Diseases of the Adrenal Gland.
9:30 a. m.—H. Clare Shepardson, M. D.—The Advantages of Protamine Zinc and Crystalline Insulin in the Treatment of Diabetes Mellitus.
10:00 a. m.—H. Clare Shepardson, M. D.—Modern Management of Diabetic Coma.
10:30 a. m.—Hans Lisser, M. D. — Advances in Ovarian Therapy by the Use of Stilbestrol and Estradiol Dipropionate.
11:00 a. m.—Hans Lisser, M. D.—Indications for and Modes of Administering Testosterone Compounds in the Male.
11:30 a. m.—Roberto F. Escamilla, M. D.—Laboratory Aids in the Diagnosis and Treatment of Endocrine Disorders.

Symposium on Nutrition

1:30 p. m.—Salvatore P. Lucia, M. D., and Nina Simmonds, Sc. D.—A Demonstration of Racial Food Habits in Relation to Treatment.
3:30 p. m.—Fred H. Kruse, M. D.—Indications for Use and and Choice of Drugs in Gastro-Intestinal Disorders.

Wednesday, January 7, 1942

9:00 a. m.—Alfred C. Reed, M. D.—Treatment of Parasitic Infestations of Intestinal Tract.
10:00 a. m.—Norman N. Epstein, M. D.—The Chemotherapy of Early Syphilis.
11:00 a. m.—Stacy R. Mettier, M. D.—Gold Therapy in the Treatment of Arthritis.
11:30 a. m.—John J. Sampson, M. D.—The Use of Potassium Salts in Cardiac Diseases.
1:30 p. m.—Francis L. Chamberlain, M. D.—The Present Status of Diuretics and Their Clinical Use.
2:15 p. m.—Gordon E. Hein, M. D.—Review of Cardiac Drugs.
3:00 p. m.—Maurice Sokolow, M. D.—Recent Concepts of Therapy of Peripheral Circulatory Collapse.

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

3:30 p. m.—John H. Lawrence, M. D.—Artificial Radioactivity in Medicine.

All sessions will meet in Toland Hall, First Floor, University of California Hospital, Medical Center.

* * *

Southern California Medical Association

The one hundred and fifth semi-annual meeting of the Southern California Medical Association was held on November 14 and 15, 1941, at the Huntington Hotel in Pasadena.

The session was held under the supervision of the following officers:

Alvin G. Foord, Pasadena, President; Raymond A. Sands, Santa Monica, Vice-President; Murriel L. Ilsley, Claremont, Second Vice-President; Edward W. Boland, Los Angeles, Secretary-Treasurer.

Councilors—John B. Doyle, Los Angeles; William H. Barrow, San Diego; John C. Ruddock, Los Angeles; Alvin G. Foord, ex officio; Edward W. Boland, ex officio.

Board of Governors: 1941—F. M. Pottenger, Los Angeles; Egerton L. Crispin, Los Angeles; Charles T. Sturgeon, Los Angeles; Fred B. Clarke, Long Beach; Carl R. Howson, Los Angeles; H. Douglas Eaton, Los Angeles; Frank R. Nuzum, Santa Barbara; Robert W. Langley, Los Angeles; Merrill W. Hollingsworth, Santa Ana.

Program of the two-day session follows:

Friday Afternoon Session

November 14, 2 p. m.

Geriatric Aspects of Otolaryngology—Victor Goodhill, Los Angeles.
Discussion by A. G. Pohlman and Fred H. Linthicum, both of Los Angeles.

The Inhibition of Lactation by the Use of Stilbesterol—B. J. Hanley, Los Angeles.
Discussion by S. J. Becka, Los Angeles; Norman H. Williams, Beverly Hills.

Criteria for the Diagnosis of Non-Dermatologic Fungous Infections—Charles E. Smith, San Francisco, Professor of Public Health, Stanford University School of Medicine.

Relation of Fecoliths to Appendicitis—William Tennison, Arcadia.
Discussion by Carl F. Doehring, Pasadena; Finis G. Cooper, Huntington Park.

Seasonal Surgery—Ross Moore, Los Angeles.
Discussion by Harold Lincoln Thompson and Ralph V. Byrne, both of Los Angeles.

Friday Evening Session

November 14, 8 p. m.

The Current Status of Coccidioidal Infections—Dr. Charles E. Smith, Professor of Public Health, Stanford University School of Medicine.

The Present Status of Virus Infections—Dr. Karl Meyer, Director of the Hooper Foundation for Medical Research, University of California, School of Medicine.

Saturday Morning Session

November 15, 10 a. m.

SYMPOSIUM—OBSCURE FEVERS

Obscure Fevers of Pulmonary and Thoracic Origin—Carl R. Howson, Los Angeles.

Obscure Fevers of Urologic Origin—Ben D. Massey, Pasadena.

Obscure Fevers of Cardiovascular Origin — Frank R. Nuzum, Santa Barbara.

Obscure Fevers from the Surgeon's Standpoint—Leroy B. Sherry, Pasadena.

The Infectious Fevers—Albert G. Bower, Glendale.

Moderator—Dr. Karl Meyer, Director of the Hooper Foundation for Medical Research, University of California.

12:00 noon—Business meeting.

Saturday Afternoon Session

November 15, 2 p. m.

Urinary Infections in Women—Rosemary Shoemaker, Los Angeles.
Discussion by Frederick A. Bennetts and Walter R. Fieseler, both of Los Angeles.

Dissecting Aneurysms of the Aorta—Thomas H. Brem, Los Angeles.
Discussion by William Nance Anderson, Los Angeles; Albert H. Elliott, Santa Barbara.

Recent Advances in Chemotherapy: Sulfadiazine and Sulfaguanidine—William R. Gibson, Los Angeles.
Discussion by Louis E. Martin and Morris H. Nathanson, both of Los Angeles.

The Character of Pain in Appendicitis—Arthur Pattison, Pasadena.
Discussion by Ray B. McCarty, Riverside; Edward C. Pallette, Los Angeles.

The Etiology and Treatment of Incontinence of Urine in Women—Franklin Farman, Los Angeles.
Discussion by Walter F. Pritchard, San Bernardino.

* * *

Southern California Medical Association

Dr. Ray B. McCarty of Riverside was elected president of the Southern California Medical Association at a closing session of the group's recent two-day convention at the Huntington Hotel. He succeeded Dr. Alvin G. Foord of Pasadena.

Others elected were Dr. John Ball of Santa Ana, vice-president, and Dr. Nelson Paul Anderson, Los Angeles, secretary-treasurer. Los Angeles was selected for the Association's spring meeting.

* * *

Butte County Society Host to District Meet

Medical men of Chico and members of the Butte-Glenn County Medical Society will play host here today and tomorrow to nearly one hundred members of the Eighth Councilor District of the California Medical Association.

The conclave, a postgraduate conference, will convene at 2 p. m. when registration begins at Hotel Oaks, at which some of the most distinguished members of the medical profession in California will be presented.

Conference Opens

The postgraduate conference will begin at 3 p. m., at which Dr. Charles Benninger, Oroville, President of the Butte-Glenn County Medical Society, will preside.

Papers on advances in the medical profession will be given by Dr. Maurice Tainter, Professor of Pharmacology, Stanford University School of Medicine; Dr. Stacy R. Mettier, Associate Professor of Medicine, University of California Medical School; Dr. Carleton Mathewson, Jr., Associate Professor of Surgery, Stanford University School of Medicine.

Deuel to Speak

At the 7:30 p. m. banquet, Senator Charles H. Deuel will speak and at 9 p. m. entertainment will begin.

The second scientific meeting of the postgraduate conference will begin at 9 a. m. Speakers will include: Dr. Stacy R. Mettier, Associate Professor of Medicine, University of California Mdical School; Dr. Carleton Mathewson, Jr., and Dr. Maurice Tainter. Dr. J. O. Chiapella, Chico, will be chairman of the group.

Dr. Frank A. MacDonald of Sacramento, Councilor, Eighth District, will preside at the luncheon organization meeting at 1:00 p. m. Speakers will include: Dr. Henry S. Rogers, President of the California Medical Association; Dr. William R. Molony, President-Elect of the California Medical Association; Dr. George H. Kress, Secretary-Treasurer of the California Medical Association; John Hunton, Executive Secretary of the California Medical Association; Ben H. Read, Executive Secretary, Public Health League of California.—Chico *Record*, November 1.

C.M.A. CANCER COMMISSION†

Semi-Annual Microscopic Conference

The semi-annual Microscopic Pathology Conference of the Cancer Commission will be held in the Science Building of the University of Southern California, University Avenue and Thirty-Six Street Place, Los Angeles, on Sunday, December 14, at 9:30 a. m. Case histories and sample slides should be sent to Dr. Roy Hammack, 657 South West lake Avenue, Los Angeles, for consideration by the committee, and reservations for the conference should be made through Dr. Otto H. Pflueger, 384 Post Street, San Francisco.

The committee in charge of the conference consists of Dr. Roy Hammack (chairman), Dr. Ernest Hall, and Dr. Newton Evans.

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† For roster of members of the Cancer Commission of the California Medical Association, see page 2 in the front advertising sction (bottom of the second column).

Records of Five-Year Cures of Cancer

The American College of Surgeons, 40 East Erie Street, Chicago, is continuing to solicit for its Cancer Archives records of five-year cures of cancer. By the term "five-year cure" is meant those cases that have remained free of clinical evidence of the disease for five years or more following treatment. The College Archives now contain records of 36,087 such cases.

The Cancer Archives of the College are intended to fulfill two purposes. The first is to accumulate as many as possible of the records on the abstract record forms that have been evolved by the College in order to amass a volume of records that will make possible a large scale evaluation of the different methods of therapy and compile statistical data on the other phases of cancer that are indicated on those forms. To accomplish this purpose the complete execution of the forms is essential.

The second purpose is to place the College in a position to inform the medical profession and the public in a numerical way of the successes that have attended cancer therapy. A simplified form of report that will be used for numerical purposes only has been prepared to make possible the reporting of five-year cures by those who for various reasons cannot execute the more detailed abstract record forms.

The College, upon request, will furnish the appropriate forms for the reporting of these cases, but the College is not in a position to distribute these forms for general use in the current cases in hospitals and clinics. . . .

COMMITTEE ON INDUSTRIAL PRACTICE

Industrial Health

Industrial health is assuming increasing importance in connection with national defense, social economy and other closely related problems. It concerns itself with industrial hygiene, occupational disease and the raising of the standard of health of the employed population. Industrial hygiene has been defined as a system of principles or rules designed for the promotion of the health of our industrial population. It involves not only the specific occupational diseases, but all phases of the industrial environment that may have an effect on the health of the worker. The recognition and care of occupational diseases and industrial hazards are coming more and more within the sphere of the practicing physician.

The medico-legal phases of industrial health are likewise presenting new problems of vital interest to the general practitioner. With the marked development of new industries throughout this country and particularly in national defense, every effort is being exerted to stimulate the interest of the medical profession in industrial health conservation. It is well to emphasize the further relation to state examining boards, because the principles of industrial hygiene, occupational disease and industrial health come properly within the requirements of medical licensure.

* * *

Western Association of Industrial Physicians and Surgeons

A dinner meeting of the Northern Section of the Western Association of Industrial Physicians and Surgeons was held at Hotel Oakland on November 4, Dr. R. T. Legge, presiding, and Dr. Christopher Leggo of Crockett, secretary.

Guest speakers were Dr. Eugene Kilgore and Dr. J. J. Sampson of San Francisco, and the topic of the evening's discussion was "Employment of the Physically Handicapped."

Plans were announced for the second annual meeting in Del Monte on Sunday, May 3, 1942. If the tentative plans materialize, guest speakers will be Dr. Carl Peterson, Secretary of the American Medical Association Council on Industrial Health, and Mr. J J. Bloomfield, Chief Industrial Hygienist, United States Public Health Department.

The following motion was passed unanimously:

Resolved, That we recognize a regrettable shortage of qualified personnel in industrial hygiene as well as a woeful lack of schools properly equipped to provide adequate training in industrial hygiene; that these lacks are most urgent in the light of national defense; that we approve in principle the proposal that the University of California at Berkeley provide, in the near future, courses leading to graduate degrees in public health; that such courses should include those offering particular emphasis on industrial hygiene; and be it further

Resolved, That the Secretary of this Association be instructed to transmit this resolution to the Secretary of the Board of Regents, University of California, to the President of the University, and to the Dean of the Medical School.

ANNUAL COUNTY MEDICAL SOCIETY REPORTS*†

FIRST DISTRICT

Imperial, Orange, Riverside, San Bernardino, and San Diego Counties; Calvert L. Emmons, Ontario, Councilor.

* * *

Imperial County Medical Society

Imperial County Medical Society now has twenty-eight members, an increase of seven over the preceding year. Two of our members are in military service.

The meetings are held monthly at the Barbara Worth Hotel, in El Centro, being preceded by a dinner. July, August, and September are our vacation months.

A postgraduate conference will be held in December.

No action has been taken concerning a grievance committee.

CLAUDE F. PETERS,
Secretary.

* * *

Orange County Medical Association

The Orange County Medical Association this year has 122 active members. The Association has lost one member through transfer and has gained five new members. Two members—Dr. Fred Earel and Dr. H. Q. Willis—were lost through death. Eight members of our Society are now in military service, and they have been exempted from paying local dues. There are very few practicing physicians in Orange County who do not belong to the local medical association.

The regular monthly meetings are held on the first Tuesday of each month, and are usually dinner meetings held in various cities of the county. There are no meetings in July and August. The programs this year have been excellent and have covered a variety of subjects. The programs are under the direct charge of a program committee, headed by Dr. C. Glenn Curtis.

A very excellent postgraduate program was held in conjunction with Riverside and San Bernardino counties on February 20, in Anaheim. In January our Society was fortunate in having Doctor Alvarez of the Mayo Clinic conduct a clinic in the afternoon and give a formal paper in the evening. This was very greatly enjoyed and resulted in a large attendance.

The Orange County Medical Bulletin is published monthly under the editorship of Dr. Thomas Rhone, and programs for the County Medical Society and hospital staff meetings are published in it. The Bulletin has been a source of slight profit to the Society by means of the advertisements which are placed in it each month. These advertisements are obtained by the business manager.

At the December meeting this year, it is planned to have the dentists unite with the medical society and entertain the two local Representatives and the Senator. Our legislative members have been very coöperative with the medical society in their stand on legislative matters of interest to medicine in general.

The Orange County Medical Association continues to enjoy almost 100 per cent membership in the Public Health League. Our members are almost unanimous in their be-

* For editorial comment, see page 282.

† County societies are arranged alphabetically, under their respective districts.

lief that this organization deserves our whole-hearted support. We all are anxious that the Basic Science Initiative be successful, and we have had practically no unfavorable comment from the citizens in this community.

The Orange County Women's Auxiliary is doing very fine work in assisting the medical society when called upon. Their meetings are held the first Tuesday afternoon in each month and are held in the homes of various members.

MILO K. TEDSTROM,
Secretary.

Riverside County Medical Association

The Riverside County Medical Association numbers eighty members, which is a slight increase over the past year. Four members are now in active military service and have been relieved of paying local dues.

Meetings are held monthly, with the exception of July, August, and September, at the Riverside Community Hospital. The programs generally consist of one or two scientific presentations, usually by a guest speaker, followed by discussion from the floor. The scientific program is followed by the regular business meeting. The bulletin is a mimeographed sheet sent out the week before the regular meeting, and contains notes on business transacted by the Council and announces the program for the following week. A special Postgraduate Committee is in charge of the postgraduate conferences. San Bernardino, Orange, and Riverside counties present their postgraduate assemblies in conjunction with each other.

Recently an amendment to the by-laws has created a Committee on Grievances and Deportment, in accordance with the suggestion of the State Committee on Medical Defense. The members have been active in obtaining signatures on the Basic Science petition, and it is expected that this measure will be favored by the citizens in this area.

The establishment of Camp Haan and the enlargement of March Field has brought physicians from throughout the country to this region for their active military service. These men receive our bulletin, and are invited and urged to attend our regular meetings. Many of them have done so.

HOBART M. KELLY,
Secretary.

San Bernardino County Medical Society

The San Bernardino County Medical Society is composed of 158 active members, an increase of two members over last year. Eight members have been called to active military duty, and our retired membership has increased to five.

Members called to active military service are exempted from dues. Notices of meetings are sent regularly to the medical men of March Field and Camp Haan, and the officers attend our meetings whenever possible.

Regular meetings are held the first Tuesday of each month, October through June, there being no meetings during the months of July, August, and September. In general, the meetings are all held in the San Bernardino County Charity Hospital, except for the annual dinner meeting held at Loma Linda Hospital, and the annual June dinner meeting held at Patton State Hospital.

The programs are usually planned by the Secretary, and members of the Society give about half of the programs, with guest speakers filling out the other half of the schedule.

Notices and programs of the meetings are announced through a bulletin published for each of the nine months in which meetings are held. The bulletin is self-supporting by paid advertisements.

We have an excellent Postgraduate Committee, composed of Doctors F. E. Clough (chairman), Charles A. Wylie, and V. M. Pinkley. This committee plans the postgraduate meeting of our county after conferences with committeemen from Orange and Riverside counties. This meeting is also held in the San Bernardino County Charity Hospital, where clinical material is readily available. These meetings are purely clinical, and start at 4 p. m. They continue through the evening, with a dinner served at 6 p. m. This meeting is held conjointly with Riverside and Orange County Societies.

The Council is now studying the proposed new by-laws for medical defense.

One political meeting is held each year, when state and county officials are guests. These meetings are always well attended, and have proved beneficial to all. Occasionally, joint meetings with the dental and legal professions are held.

The Woman's Auxiliary was disbanded some years ago, and it has not seemed possible to reorganize since.

The County Hospital is managed through an advisory board composed of members of the Society, and all members of the staff must be members of the Society. All connections between the Board of Supervisors, the Society, and the Hospital have been most pleasant, and only the closest coöperation has obtained.

The County Hospital accepts pay patients in the isolation and tubercular wards for those cases not admitted by private hospitals. No other pay patients are admitted. At present, we are happy to report, the County Charity Hospital is not a problem in San Bernardino County, and we trust that this situation will continue.

ARTHUR E. VARDEN,
Secretary.

San Diego County Medical Society

The membership of the San Diego County Medical Society totals 300. At the time of this writing, about thirty applications are also on file. Thirty-two members are in military service. Such members are exempted from local dues. The printed bulletin of the Society is sent to the Army posts in this territory. Meetings are held once a month, except during July and August.

Postgraduate conferences are held yearly. Through by-law adoption, a Grievance Committee has been brought into being.

The Woman's Auxiliary has given very good aid in educational work and other campaigns.

The San Diego Hospital accepts no pay-patients except under emergencies. At the present time there is a lack of hospital beds in the private institutions. Steps are being taken to remedy this deficiency. Considerable agitation has been carried on concerning hospital care of indigents who are not eligible for care in public institutions.

W. H. GEISTWEIT, JR.,
Secretary.

SECOND DISTRICT

Los Angeles County; George D. Maner, Los Angeles, Councilor.

Los Angeles County Medical Association

The year now ending has been one of the most active in the history of the Los Angeles County Medical Association, with action directed specifically to problems affecting every practicing doctor of medicine, and with intent to get results.

In this year of turmoil the Council, the Board of Trustees, officers and the various committees of the Association, planned their respective activities upon the thesis that results alone count.

And results were obtained.

The year began with one of the most ambitious Public Relations activities ever conceived of by any county medical society—the Los Angeles County Health Defense Exposition—which was held February 2 to 9 inclusive, at the Shrine Ballroom in Los Angeles. Scientific and commercial exhibits, all designed to help educate the public in matters of medicine, and occupying 100,000 square feet of space, presented a spectacular show for the many thousands who came to see it. A dramatic story of what Medicine has accomplished, and what Medicine is doing, was presented in a most dramatic manner.

Publicity resulting from the Health Defense Exposition exceeded 6,000 column inches in the press, together with more than 400 cuts. Much radio publicity was obtained, major stations broadcasting from the floor of the Exposition.

The second major Public Relations activity of the Los Angeles County Medical Association was an exhibit at the Los Angeles County Fair at Pomona, September 12 to 28. A half-million and more people saw this exhibit. More than 2,000 stopped at the booth each day of the Fair, requested literature and asked many questions. Booklets and leaflets prepared by the American Medical Association, for sale to the public, were distributed gratis to those who stopped at the Association's booth. Almost the entire supply of this material, held in the stock rooms of the American Medical Association in Chicago, was used, clearing their shelves, as Dr. W. W. Bauer, Director of the Bureau of Health Education of the American Medical Association, stated in a telephone conversation when more of this literature was called for.

Space at the Fair next year has already been reserved.

These two events stand out in our public health educational program this year, but Public Relations activities are continually carried on. Rarely a day passes but that a member of the Speakers' Bureau appears before some lay organization, carrying to the people the message of Medicine.

The radio program of the Association has entered into its eleventh year of continuous weekly broadcasts; two of fifteen minutes each over two prominent stations—KFI and KFAC. From requests for further literature on subjects of given broadcasts, it is estimated conservatively that the listening audience of the Association's programs

consists of from 75,000 to 100,000 listeners, spread from the central part of the state to the Mexican border.

Press relationships have been greatly improved during the past year. Much favorable publicity has been obtained through activity designed to create news value. For instance, the Flower Show held in October in the Lounge of the Association achieved three full columns of publicity in the Los Angeles *Herald-Express*, and two full columns of publicity in the Los Angeles *Times*.

While Public Relations have been given the spotlight this year, because they are vital to the preservation of the profession, other activities have not been neglected:

A tremendous amount of work has been done by our Committee on Medical Defense, which is carrying on a most extensive and intensive attack on the malpractice problem with notable results. The work of this committee during 1941 deserves, we believe, a special report which should be read by every doctor of medicine in the state.

During this most active year all other standing committees of the Association, together with a number of special committees, have been exceedingly busy and productive of results.

The Association has enjoyed a healthy growth during the year, in spite of losses due to military leaves of absence, deaths, etc., the active membership at the writing of this report being 2,551, while 162 new members have been admitted since January 1. Changes in membership status are as follows: Deceased members, 24; retired members, 22; members resigned, 1; members transferred, 7; on leave of absence, 199; dropped from membership, 23.

A number of interesting, well-attended general meetings were held during the year.

L. A. Alesen,
Secretary.

THIRD DISTRICT

Kern, San Luis Obispo, Santa Barbara, Ventura, and Inyo-Mono Counties; Louis A. Packard, Bakersfield, Councilor.

Kern County Medical Society

Kern County Medical Society has a total membership of sixty-nine members, an increase of five members since January, 1941. Six members are now in military service: Doctors H. W. Bell, C. B. Stockton, John J. Cawley, James G. Ware, Frank McDonald, and Leo Baisinger. The Society has lost three members by death: Doctors O. P. Goodall, C. A. Morris, and J. A. Chapman.

Meetings of the Society are held on the evening of every third Thursday, except in June, July, and August, at the Padre Hotel in Bakersfield. One meeting is held yearly in Taft.

The Society sends out a monthly bulletin, and during the year special effort was made to include items concerning California Physicians' Service. A proposed amendment to the by-laws of the Society will exempt members in military service from payment of dues. The Constitution of the Society conforms to the standards outlined in the Brochure on Medical Defense.

Dr. Keith S. McKee has served as program chairman for the year and guest speakers have been invited, usually from Los Angeles, with one meeting being presented by members, a symposium on undulant fever, with papers by Doctors Robert Scherb, Carl Moore, and John J. McCarthy.

An outstanding refresher course in obstetrics was given June 16, 17, and 18, with two speakers each evening. Doctors J. Headen Inman, Roderick Ogden, and James Stanton constitute the Postgraduate Committee, and are arranging for a Postgraduate Conference for March, 1942. Many members attended the Conference held in Santa Barbara on March 29, 1941.

On March 20, Doctors Henry S. Rogers and George H. Kress spoke on problems confronting the California Medical Association. Members of the Society have coöperated in securing signatures on the Basic Science Law petitions, and were addressed by Mr. Ben Read of the Public Health League on this subject on October 16.

The physicians of Kern County have coöperated with the Agricultural Workers' Health and Medical Association in providing medical care for migrant farm workers. Prenatal clinics, to be established at the Farm Labor Camps, have the approval of the Society. The Society also is cooperating with the Red Cross, and is aiding in the formation of classes for volunteer nurses' aides.

A special campaign for education regarding cancer was carried on under the direction of the American Society for the Control of Cancer. A Tumor Committee to consult on cases referred by private physicians was established at the Mercy Hospital. Serving on this committee are Doctors F. J. Gundry, William Moore, James Ware, J. Headen Inman, and Roderick Ogden. The A. A. U. W. contributed valuable services during the campaign in distributing literature.

The Society contributed $25 to the National Physicians' Committee. Individual members have contributed their services to community organizations such as the Community Chest, Boy Scouts, and the Kern County Tuberculosis Association. A Speakers' Bureau has been organized and has been called upon for talks on medical subjects.

The status of the court action of Dr. Joe Smith vs. Kern County Medical Society has been of interest and the case is now before the Supreme Court of California. Recent developments in the county have resulted in the dismissal of Doctor Smith as superintendent of the Kern General Hospital by the Board of Supervisors.

The Society has had the full coöperation of the Woman's Auxiliary and appreciates its services. The press aided especially in the publicity campaign concerning cancer.

Officers during 1941 were: Lucille B. May, president; James Stanton, vice-president; Sophie M. Loven, secretary.

Serving on the Board of Directors were: F. J. Gundry, C. I. Mead, R. A. Ogden, William H. Moore, H. W. Lange, C. S. Compton, and Seymour Strongin. Delegates were: F. J. Gundry and C. S. Compton, with J. M. Nicholson and Eric F. Colby as alternates.

Sophie M. Loven,
Secretary.

San Luis Obispo County Medical Society

The following is a brief report of the San Luis Obispo County Medical Society:

During the past year, two new members have been initiated into the Society and two members have moved out of the county, still leaving a membership of thirty-five.

The Medical Society is now associated with the county hospital in an advisory and consulting capacity.

Monthly meetings have been held during the past year, with a scientific program at each meeting. At the meetings the medical personnel of the local Army camp, Camp San Luis Obispo, has been well represented.

There are no publications by the Society.

Joseph G. Middleton,
Secretary.

Santa Barbara County Medical Society

The Santa Barbara County Medical Society has an active membership of 115. Regular meetings are held on the second Monday evening of each month, except July and August, in the auditorium of the Santa Barbara Cottage Hospital. The January meeting is always a dinner meeting and was held in the Service Clubroom of El Paseo restaurant. Entertainment consisted of orchestra music, singing, and magic by the well-known Maldo.

Three members of the Society belonging to the Naval Reserve have been called to active duty. They are Dr. Edward Markthaler, Dr. J. Kenneth Patterson, and Dr. D. H. McNamara. Doctor McNamara has been the secretary of this society for the past two years. The Society voted to exempt members in military service from local dues.

Guest speakers for the past year consisted of the following:

February—Dr. Oswald S. Lowsley of the Brady Urological Clinic, New York City, "Diagnostic Procedures in Urology."

April—Dr. H. C. Lindsey of Pasadena, "Skin Diseases."

May—Dr. R. A. Scarborough of San Francisco, "Anal Cryptitis"; Dr. Malcolm Hill of Los Angeles, "Pruritus Ani."

June—Dr. Vernon P. Thompson of Los Angeles, "Body Mechanics."

September—Dr. William J. Kerr, Professor of Medicine at the University of California, "Cardiac Irregularities."

This society publishes a mimeographed monthly bulletin, which has been of considerable value in disseminating information to the members.

Through the efforts of Dr. Horace Coshow, sufficient funds have been offered by Mrs. Emma Wood of Carpinteria, California, to provide a complete medical library for the Santa Barbara County Medical Society. The library will be in a wing of the Santa Barbara Cottage Hospital. Members of the Society will contribute annually toward the support and maintenance of the library.

H. I. Burtness,
Acting Secretary.

Ventura County Medical Society

The Ventura County Medical Society has fifty-three active members. This is one less than a year ago. There are five members in active military service—two in the Army and three in the Navy. One new member was admitted by initiation during the year and another admitted by transfer. Three members were lost by transfer. There

are sixty-eight physicians licensed in the county. In addition, there are fifteen chiropractors and fourteen osteopaths.

Members in military service are exempt from local dues.

Meetings are held monthly, except July and August, at the Ventura County Country Club at Saticoy on the second Tuesday. A dinner precedes each meeting. Individual members take turns in serving as program chairman. Each meeting is announced by post card, sent to every active member.

In March we were favored by the presence of President Henry S. Rogers, Dr. George H. Kress, and Dr. Louis A. Packard, Councilor of this, the Third District.

In October a joint meeting was held with the members of the Dental Association, at which time Mr. Ben H. Read, Secretary of the Public Health League, presented details regarding the proposed Basic Science Initiative. At the same meeting, Senator J. J. McBride discussed legislation. We believe that the Basic Science Initiative will receive overwhelming support in our county.

Postgraduate activities consist of participating with other county societies in our Councilor District.

The Woman's Auxiliary has been of assistance in furthering public health education. Several meetings have been held.

The Society is represented on the Ventura County Public Health Advisory Committee. This, together with the splendid coöperation of our full-time county health officer, Frank E. Gallison, gives the Society close contact with all public health matters.

The Society recently appointed a Grievance Committee. It is hoped that it will never be necessary for it to function.

Medical preparedness has been supported by the Society. The medical personnels of the local aviation training center and the United States Maritime School have been invited to attend our meetings.

In general, our members have coöperated in establishing the California Physicians' Service.

The Ventura County Hospital efficiently looks after the indigent sick.

For about six months an FSA migrant camp was established in the county. Recently it was abandoned for lack of clients.

About 30 per cent of our members support the Public Health League of California. It is hoped that more will do so in 1942.

R. K. Harker,
Secretary.

Inyo-Mono County Medical Society

Inyo-Mono County Medical Society, youngest of the component units of the California Medical Association, has eight active members. In addition, four members of the dental profession are affiliated in the work as associate members. One member is in military service.

The monthly meetings are usually held in Bishop, with an occasional meeting in Independence. Because of the weather conditions, the vacation months of the Inyo-Mono County Society are December, January, and February.

A county unit of the State Woman's Auxiliary was formed during the past year.

Owing to the comparatively sparse population in the two counties, no county hospital is supported.

During the past year, State Association officers and guest speakers from Kern and Santa Barbara counties participated in our meetings.

George D. Shultz,
Secretary.

FOURTH DISTRICT

Calaveras, Fresno, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tulare, and Tuolumne Counties; Axcel E. Anderson, Fresno, Councilor.

Fresno County Medical Society

Membership of the Fresno County Medical Society was increased by six members, and there is now a total of 148 names on the roster. Seven of the members are in military service. Local dues of military members have been exempted, and we are sending notices of our meetings to near-by Army posts.

The monthly meetings are held in the University Club, except during July and August when there are no meetings. We avail ourselves of guest speakers from the university centers.

The Postgraduate Conference will take place within the next several months.

Our Woman's Auxiliary is active, and can be counted upon to give good support in promoting the Basic Science Law.

J. E. Young,
Secretary.

Kings County Medical Society

The Kings County Medical Society has twenty-one active members. There were five new members added during the year and two members were lost—one of these by transfer and the other entered the United States Army.

There were nine meetings held during the year. Two of these were of special interest. One was a banquet given in honor of the nurses of Kings County, and the other a banquet at which the guest speakers were: Mr. John Hunton, Executive Secretary, who spoke on the Basic Science petitions; Mr. Read of the Public Health League, who spoke of the work of his committee at Sacramento during the last session of the legislature; and Doctor Rector, who spoke to the Society members on "The Clinical Consideration of Acute Illness of the Child." Another banquet meeting was held, at which the County Board of Supervisors were guests. The subject of the evening was a discussion of Kings County Hospital and part-pay patients.

A goodly number of names have been obtained for the Basic Science Initiative by the Society members.

Arthur Zeismer,
Secretary.

Merced-Mariposa County Medical Society

Active membership during the year totaled thirty-nine, being an increase of five members over the previous year. Six of our members are in military service.

Regular members have been exempted from payment of dues, and the Commanding Officer of the Medical Corps in the near-by Army post has been notified of the meetings which were held in Merced, except during June, July, and August.

Among the guest speakers on scientific topics were Dr. Zera Bolin and Doctor Leon Parker, both of San Francisco. State President Henry S. Rogers, Councilor A. E. Anderson, and Secretary George H. Kress gave addresses on organization topics.

The annual picnic of our county society was held in June in Henderson Park.

The Woman's Auxiliary to the California Medical Association is coöperating with our county units.

At the County Hospital the undersigned acts as medical director of obstetrics and pediatrics. Patients are admitted on a private patient pay basis.

James A. Parker,
Secretary.

San Joaquin County Medical Society

Of our group of 112 active members, seven are now in military service. Meetings are held monthly in the clubrooms in Stockton, except in July and August. Monthly meetings are preceded by dinner sessions.

Among the guest speakers who have visited us are Doctors George W. Pierce, George Olson, Leo Eloesser, Clifford Sweet, Phillip R. Arnot, S. P. Lucia, Emile Holman, and Chauncy D. Leake.

The postgraduate conference is being contemplated for February or March. The Society has appointed a Grievance Committee. Reaction of the citizens to the Basic Science Law is favorable.

The Woman's Auxiliary of the San Joaquin County Medical Society carries on active work.

We have no direct or indirect connection with the medical staff of the County Hospital.

C. A. Broaddus,
Acting Secretary.

Stanislaus County Medical Society

During the year 1941, the Stanislaus County Medical Society has maintained a membership of forty-eight. Six new members were accepted into the Society, one member has transferred his membership to Fresno County, and three members are in the military service.

Meetings are held on the second Friday of each month, with the exception of July, August, and September, at 7 p. m. at the Hughson Hotel, Modesto. During 1941 one informal meeting was held at the ranch of Dr. E. V. Falk on a Saturday afternoon in July, and one meeting was held in Turlock at the home of Dr. Marion Collins.

The following physicians have presented papers to the Society: Gerald O'Connor on "The Early Plastic Repair of Injuries"; T. L. Althausen on "Medical Treatment of Cholecystitis"; Amos Christie on "Recent Developments in Pediatrics"; Gerald Crenshaw on "Nontuberculous Conditions of the Chest"; H. Glenn Bell on "Recent Advances in Gastric Surgery"; L. D. Howard on "Surgery of the Hand and Tendons."

The Committee on Constitution formulated a new constitution for the Stanislaus County Medical Society early in the year. Since then the constitution has been amended to include a Committee on Grievances and Deportment.

The Woman's Auxiliary, during the year, has sponsored an occupational therapy program at the Stanislaus County Hospital. Through a benefit bridge party, funds were raised for contribution to the State Needy Physicians' Fund. During the coming month, the Auxiliary intends to sponsor the Basic Science Initiative campaign.

A. E. GHILOTTI,
Secretary.

Tulare County Medical Society

The Tulare County Medical Society has held two regular meetings and one special meeting since the summer vacation period. The special meeting was called so that the members might meet with Director Larsen of the California Physicians' Service. This Society is always pleased to meet with the officers of any of the branches of statewide medical activity.

The past year has been quite free of incidents which have necessitated special consideration on the part of the local society.

Our number of active members has been reduced to forty-six, as Drs. F. Cooley, F. DeBusk, H. Falk, D. MacKinnon, L. Seligman, and E. Zumwalt are at present in the Army Medical Corps.

We have on file one application.

F. G. POWELL,
Secretary.

FIFTH DISTRICT

Monterey, San Benito, San Mateo, Santa Clara, and Santa Cruz Counties; R. Stanley Kneeshaw, San Jose, Councilor.

Monterey County Medical Society

The roster of the Monterey County Medical Society contains sixty-seven members. Two have been transferred to other counties. In addition to the regular membership, all officers of the Medical Corps posted at the Presidio of Monterey and Fort Ord are honorary members and are entitled to all privileges of membership, except that of voting.

Ten regular meetings were held this year, there being no meetings in July and August, the summer months. The meetings are held alternately at Hotel Del Monte and Santa Lucia Inn, Salinas, notices of which are mailed to members by the Secretary.

During the present year the regular meetings have had very interesting speakers as guests. In January, Doctor Barnett spoke on the treatment of syphilis; Dr. H. Buckley, on the treatment of gonorrhea; Doctor Merrill of the State Department of Health, on venereal control. At the March meeting, Dr. S. Kneeshaw gave an interesting talk about the California Medical Association; Dr. George Waters of San Jose spoke on fractures; and Doctor Josephen, also of San Jose, spoke on foot disorders. The June meeting had as its guest speaker, Doctor Horwitz of the University of California. His subject was "Third State of Labor." Mr. B. Read spoke on "Basic Science Initiative" at the September meeting. In October, Dr. L. Hawkinson spoke on "Endocrinology." The November meeting was held at the Station Hospital, Ford Ord. Major Craft and his staff entertained the Society at dinner and after the regular business meeting, interesting subjects were introduced by Major John L. Gallagher and Captain E. E. Ludmell.

The Woman's Auxiliary to the Monterey County Medical Society meets at the same time as the Society. They have coöperated to the fullest extent in entertaining the different guests at the various meetings.

The County Public Health Department maintain general clinics in Salinas, Monterey and King City, and special groups such as Chest Clinics and Well-Baby Clinics. They have done much to aid the indigent and have not in any way hurt the private practices of the members. Members of the Society act as visiting consultants in these clinics and at the County Hospital in Salinas. In addition to the County Hospital, there is a tuberculosis sanitarium with a capacity of about seventy beds. A full-time Social Service Department is maintained at the County Hospital, and in addition there is a full-time worker in Monterey.

ROBERT D. MACE,
Secretary.

San Benito County Medical Society

Membership: Number of active members, six; decrease of one over last year. Number of members in military service, 2—one in United States Army and one in Canadian Army.

There are nine licensed physicians, who are in practice in San Benito County.

The meetings are held from time to time in Hollister, upon call of the President.

I believe the proposed Basic Science Initiative will meet with favor by the citizens of our district.

The Woman's Auxiliary to the San Benito County Medical Society meets with that of the Monterey Society.

Our society has no direct or indirect connection with the medical staff of the San Benito County Hospital. The County Hospital does not accept pay patients. There is no hospitalization available for contagious cases, excepting at the County Hospital.

L. E. SMITH,
Secretary.

San Mateo County Medical Society

The San Mateo County Medical Society holds meetings each month, with the exception of June, July, and August, the vacation period. These meetings, which are planned jointly by the Secretary and the Program Committee, are held in different sections of the county, and they consist of a dinner, followed by a short business meeting and a discussion of some medical or surgical topic by someone well versed in the particular topic under discussion.

During the past year, four new, and three transfer members were accepted in the Society, and the present membership is 100 per cent of eligible physicians.

The Society has a Woman's Auxiliary, which ordinarily meets on the same night as our society. Two or three times a year, the Society and the Auxiliary hold joint meetings.

Due to the proximity of our county to San Francisco, and the constant opportunity there for postgraduate work, no postgraduate studies have been pursued by members of our society.

THOMAS E. FARTHING,
Secretary.

Santa Clara County Medical Society

The Santa Clara County Medical Society has had another progressive and successful year. Our membership has continued to grow, beginning the year with 197 members; seventeen new members were elected, but one member was lost by death, and three by transfer, making the net gain, thirteen. Membership at the end of the year is, thus, 210. There are pending seven applications which will be presented for election shortly after the first of the year. Six members are in military service of the United States, and one in that of Great Britain.

The scientific meetings have been outstanding for their variety and interest. The County Hospital program in January was presented, as usual, by the resident staff, with a cross section of their methods and material. For next year our society has offered an award for the outstanding paper presented on this program. The guest speakers for the other regular meetings have been excellent, namely: Dr. P. K. Gilman, discussing military medical problems; Drs. L. Henry Garland and Stanley Mentzer holding a symposium on gallbladder disease; Drs. Fred Rodenbaugh and Alson Kilgore heading a seminar on malignant diseases; Dr. Ray Lyman Wilbur discussing the Government's relation to medical practice; and Dr. George Pierce discussing plastic surgery, with some interesting pictures. Part of several meetings have been given over to open discussion of legislative matters and California Physicians' Service. The golf tournament and barbecue were held at the San Jose Country Club in June as a joint meeting with the Woman's Auxiliary.

The Council meetings have been well attended, a great volume of business being conducted. The attendance seems to have been stimulated by the meetings being held in the Councilors' homes. Among the efforts of the Council have been formulation of a suggestive fee schedule for general practitioners; the attempting to arrange a standard sobriety examination; and the founding of a central outlet for the members doing charity public health work. A Maternal Mortality Committee has also been set up for studies and suggestions. Recently, a temporary Grievance Committee was appointed for the duration of the year until the duties could be assigned to a committee under our Constitution.

In conclusion, it may be said that our year has been filled with many problems, none of which have been particularly outstanding. The Basic Science Initiative is our problem of the moment and our members are doing a good job in getting the petitions signed.

LEON P. FOX,
Secretary.

Santa Cruz County Medical Society

Under the active and able leadership of President Avery E. Wood of Watsonville, the Santa Cruz County Medical Society is concluding a very successful year. As has been its habit for many years, the Society has held monthly meetings, except in June, July, and August, at the Club Rio del Mar, Aptos, which is conveniently located for both the Santa Cruz and Watsonville members.

The programs are arranged by the President and Secretary, and an attempt is made to vary the subject matter

to appeal to the particular interests of all members during the year. The following speakers have appeared during 1941: Doctors George Rhodes (general surgery), Daniel Morton (obstetrics and gynecology), Amos Christie (pediatrics), Gordon Hein (internal medicine), J. W. Morgan (proctology), F. C. Bost (orthopedics), Charles Richards (roentgenology), C. L. Callendar (surgical anatomy), and E. H. Eiskamp (local practitioner).

The membership as of November 1 was forty-five. There are three members in the military service. Doctors Robert B. Case and Asher Havenhill are in the Army Medical Corps; Dr. Phillip K Gilman, Jr., is in the Navy Medical Corps. Members in the military service are exempted from local dues. Regular notices of our meetings are sent to the officer in command at Ford Ord and Camp McQuaide, which are located in this vicinity.

The Society maintains a Postgraduate Committee. During the year, one such conference was held jointly with Monterey County. The Society has a Grievance Committee, and a by-law relative to it has been adopted and incorporated in the Constitution of the Society.

Programs on organized medicine have been sponsored by the Woman's Auxiliary, which is quite active in this county. The Auxiliary has done excellent work. Among other meetings, one was held recently in Watsonville, and conducted as a joint meeting with the Watsonville Women's Club. At this meeting, John Hunton, representing Dr. George H. Kress, lectured on organization for local medical defense. It is planned, in the near future, to have a joint meeting with the attorneys and dentists of the county.

SAMUEL B. RANDALL,
Secretary.

SIXTH DISTRICT

San Francisco County; John W. Cline, San Francisco, Councilor.

San Francisco County Medical Society

The past year has been a full and, as usual, an unfinished one. For future records, if not by way of epitaph, we list herewith some of the things accomplished, and more of the unaccomplished:

1. *Scientific Programs.*—There have been three symposia. The average attendance at these meetings was one hundred. There was one general meeting on the subject of improving public sickness-service systems, or so-called health insurance, at which over 175 members attended.

2. *The Blood Bank.*—The Irwin Memorial Blook Bank of the San Francisco County Medical Society was initiated, and has functioned successfully since June, 1941. Our blood bank is said by national authorities to be the finest in the United States. It is the only one operated by a county medical society. In addition to its present function as a blood reservoir for the community, it is soon to collaborate with the National Red Cross in taking blood from over 10,000 donors for the exclusive use of the Red Cross and the United States armed forces.

3. *Health Insurance.*—The continued development of sickness service systems has occupied much of the time of the Society's officers. The San Francisco Municipal Employees' Health Service System required protracted attention, eulminating in a referendum submitted to the membership last March. Approximately 80 per cent responded to the referendum with an affirmative vote, thus endorsing the Committee on Health and Hospitalization Insurance, and demonstrating that over eight hundred doctors can unite and present an unbroken front to uphold their rights. The lay board of directors, which operates the Health Service System, accepted the Society's vote and immediately adopted the fee schedule which we drew up. In 1940, we succeeded in having adopted a charter amendment requiring (not just permitting) an annual review and open hearing on the operation of this system. In 1941, we had a basic medical fee schedule adopted and a genuine arbitration committee set in motion. These may seem like minor steps, hut they are not; they are fundamental ones and required much effort to achieve. In April, 1941, we saw the issuance of Volume I, Number 1 of Health Service Facts, the physicians' bulletin on the Municipal Health Service System; this was distributed to every one of the 16,000 municipal employees. In August, 1941, a revised hospital contract was adopted, a great improvement over the former one, eliminating flat-rate coverage for certain medical services, and equalizing certain hospital burdens.

4. *California Physicians' Service.*—Partly through the efforts of our elected delegates to the California Medical Association and partly through the constructive work of our regional coördinators, two fundamental changes were made in California Physicians' Service: the limitation of full coverage contracts and the allocation of increased premiums to groups known to be high risks.

5. *National Youth Administration.*—Largely through the actions of our president, a proposed central clinic for National Youth Administration clients was forestalled, and instead the diagnostic program of this organization was diverted into existing medical channels, employing private practitioners, with resultant benefit to youths and the profession alike.

6. *Relief Medicine.*—A Committee on Relief Medicine was established and the Public Welfare Commission of the City and County of San Francisco was persuaded to appoint a medico-dental advisory committee in order that physicians might assume their natural responsibility in the conduct and operation of the medical aspects of relief problems.

7. *Tuberculosis Surveys.*—The question of surveying domestics was made the subject of a special committee report and the matter submitted to the Junior Chamber of Commerce for joint action. A proposal to utilize the County Hospital for making a survey of the personnel of the San Francisco school department (the annual budget of which department is some $13,000,000) was rejected and the school department was given every assistance in order to initiate the survey under proper conditions. The school department has not availed itself of this assistance to date.

8. *Military Medicine.*—The County Medical Society established a record for coöperation with State Selective Service Headquarters and efficient handling of selective service examinations. Largely through the actions of the Society, certain difficult and impractical proposals, relative to 4-F classifications, were deflected.

9. *San Francisco Civil Defense Council.*—The facilities of the Society were placed at the disposal of the San Francisco Civil Defense Council and the Disaster Commission of the San Francisco Red Cross.

10. *Community Chest.*—At the suggestion of the Secretary, the Community Chest issued publicity releases to inform the public of the great amount of free medical care given by the physicians of this city. The Speakers' Bureau of the Chest has released appropriate statistical data to its members for further dissemination of these facts.

11. *Revision of the Constitution, By-Laws and Principles of Professional Conduct.*—Important revisions of the Constitution, By-Laws and Principles of Professional Conduct were drafted by the Committee, which worked diligently on this problem.

12. *Reduction of Athletic Injuries.*—A Committee on the Reduction of Athletic Injuries was appointed.

13. *Coöperation with Insurance Companies.*—Meetings were held with representatives of several major companies which write medical-expense insurance. The companies were asked to simplify their medical report forms and to clarify the nature of the fee schedules they frequently issue. The companies agreed to introduce suitable wording at the head of such schedules to the following effect: "The fees allowed do not necessarily indicate the fees which your physician or surgeon may charge; your case may call for higher fees, and you may apply the sum allowed under your policy toward payment of the full fee charged." Some of the companies have already started making checks payable jointly to the patient and physician, thereby assuring the latter that he will recover his fee in indemnification cases. In return, the Society undertook to encourage its members to coöperate more vigorously with insurance companies, to secure authorizations when such are needed, and to complete their reports promptly and accurately as possible.

14. *Standards of Admission to Clinics.*—The proposed new standards of admission to clinics submitted by the Community Chest were studied by the Society's directors, and the Chest requested to defer their enforcement in so far as a 10 per cent increase in income levels was concerned.

15. *State and National Medical Legislation.*—The Society coöperated with the Public Health League of California and the National Physicians' Committee for the Extension of Medical Care in the continuation of their respective programs.

16. *Public Relations.*—The Society continued the employment of Public Relations counsel for advice and assistance on matters in which the public's attitude toward the medical profession was involved. The advice, the assistance, the hard work performed by our Public Relations counsel, Mr. William J. Losh, is unrepayable in mere money.

17. *The Bulletin* has changed its format slightly and is apparently more readable, or at least more read. At any rate, we sold more individual copies to nonmembers this year than ever before! We think it can be much further improved, but do not know how to find the time to do it. The dull topics of medical organization matters need much polishing, even to glow in daylight.

18. *National Physicians' Committee.*—During the year the Public Relations counsel released numerous editorials and informative material prepared by the National Phy-

sicians' Committee, and secured publication of these important articles in many newspapers in the Bay district.

19. *Membership.*—Total number of active members is 1,040, an increase of forty-nine over the previous year. Fifty of these members are in military service. Military members are exempted from the payment of local dues.

L. Henry Garland,
Secretary.

SEVENTH DISTRICT

Alameda and Contra Costa Counties; Frank R. Makinson, Oakland, Councilor.

Alameda County Medical Association

The year just past has been a very busy one for our Association, with special effort devoted to problems of medical preparedness. Much work has been done and is still being done on a plan for more efficiently handling medical examination of draftees by specialty groups. By such a plan these examinations are raised to a higher scientific level and the work is done at great saving of time to the doctors donating their services. Our members are coöperating with Civilian Defense organizations. They are aiding the American Red Cross in a plan to man the many first-aid stations being established throughout the county, and also in the organization of hospital staffs for emergency service in event of disaster. The details of these plans are under the very able direction of Dr. Clarence DePuy, a member and past president of the Alameda County Medical Association.

As is our custom, the Association has held regular meetings each month, except for the vacation months of July and August. Most of the papers were presented by local members, but two visiting speakers honored us—Dr. Bruce Douglas of Detroit, who spoke on the problems of tuberculosis; and Dr. Morris Fishbein, who discussed medical preparedness.

Our Association gratefully acknowledges the faithful coöperation of its Auxiliary, to whose efforts we owe the solution of many trying problems.

Gertrude Moore,
Secretary.

Contra Costa County Medical Society

At this time the membership totals sixty. Ten meetings were held during the past year, each of which was composed of a business session as well as a scientific program, with the exception of the December meeting. The December meeting is the occasion of the annual Christmas dinner dance of the Society. The scientific programs have consisted of interesting discussions by guest speakers, clinico-pathologic conferences and surgical motion-picture films.

L. Abbott Hedges,
Secretary.

EIGHTH DISTRICT

Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Placer-Nevada-Sierra, Plumas, Sacramento, Shasta, Sutter, Tehama, Yolo, and Yuba Counties; Frank A. MacDonald, Sacramento, Councilor.

Butte-Glenn County Medical Society

Butte-Glenn County Medical Society has thirty-eight members, of whom three are in military service. Military members have been exempted from the payment of county society dues.

The Society meets monthly, usually at Chico or Oroville, except during the vacation months of June to September.

The Society sponsored the arrangements for the Eighth Councilor District Postgraduate Conference recently held in Chico.

The Woman's Auxiliary to the Society has done excellent work.

Five of the Society members are on the medical staff of the County Hospital.

J. O. Chiapella,
Secretary.

Lassen-Plumas-Modoc County Medical Society

The Lassen-Plumas-Modoc County Medical Society has had another successful year under the presidency of Dr. William B. McKnight of Portola.

Meetings have been held at various places throughout the three counties so as to make it possible for members at distant points to have an opportunity to attend at least some of the meetings. Dinners were usually held prior to the meetings, and the Woman's Auxiliary held its meetings on the same dates.

At present there are seventeen active members, and Doctors A. Velarde of Portola and W. B. Magg of Greenville have been approved for membership and will be voted on at our next regular meeting. Dr. Herman Schwartzman of Rich Bar resigned to go into active military service.

A meeting early in December is being planned, at which time our new officers, delegates, and alternates will be elected.

Bernard S. Holm,
Secretary.

Placer-Nevada-Sierra County Medical Society

The Placer-Nevada-Sierra County Medical Society, at the time of the 1940 annual statement, reported forty-seven members. This was an all-time high. During the past year, four members have been granted transfers to other county societies, and one has resigned because of illness. This leaves a net membership, as of this date, of forty-two. Three of these members are in the national service and two are retired.

As has been the custom for many years, our society has held meetings, not on regular specified dates, but at the call of the President. There have been seven meetings in the past medical year:

The annual meeting of 1940 on November 9, 1940. This was a dinner meeting at the Freeman Hotel, Auburn. There were seventeen members and eight visitors present. Dr. Frank MacDonald, Councilor for the Eighth District, was present and addressed the Society members, and Dr. Joe B. Catton of San Francisco, author of "Behind the Scenes of Murder," gave a most interesting address.

January 11—Dinner meeting at the Freeman Hotel, Auburn. Twenty-three members and two visitors were present. Dr. R. C. Atkinson, at that time a member of our society, presented a paper on "Torsion of the Testicle." Dr. James R. Dillon, Professor of Surgery and Chief of the Department of Urology of the Stanford University School of Medicine, discussed "Treatment of Prostatism."

March 8—Dinner meeting at the Bret Harte Inn, Grass Valley. Twenty-one members and four visitors were present. Dr. Charles A. Dukes, past president of the California Medical Association, chairman of California Cancer Commission, and member of the National Committee on Medical Preparedness, addressed the Society.

May 26—Dinner meeting at the Cottage Inn, Roseville. Fourteen members and six visitors met to honor Henry S. Rogers, President of the California Medical Association. The meeting was addressed by Doctor Rogers, Mr. John Hunton, Executive Secretary of the California Medical Association; Mr. Hartley F. Peart, General Counsel of the California Medical Association; Dr. Frank MacDonald, Councilor for the Eighth District; and Doctors F. N. Scatena and Azevedo, both of Sacramento.

August 23—Meeting held at the Freeman Hotel, Auburn. Eleven members and four visitors were present. This was for the purpose of discussing medical defense and best method of coöperation between physicians and the Civilian Defense Council. The speakers were: Captain Pool of the State Guard; District Attorney Sparks, Doctor McKinnon of Placerville, and Mr. Guy Brundage of Auburn, President of the Placer County Red Cross.

September 27—Dinner meeting at the Freeman Hotel, Auburn. This was a joint meeting with the dentists of Placer, Nevada, and Sierra Counties. There were sixteen members and twelve visitors present, eight of the latter being dentists. The meeting was addressed by Ben H. Read, Executive Secretary of the Public Health League of California; John Hunton, Executive Secretary of the California Medical Association; and by Dr. John R. Upton. The latter gave a complete description of the San Francisco blood bank.

September 30—Special meeting at the Freeman Hotel. Six physicians, residents in Placer County and members of the Society, met and discussed coöperation with the Trustees of the Placer Union High School and Junior College in the solution of various medical problems at the High School and Junior College.

The officers for 1941 have been as follows: President, Lucas W. Empey of Roseville; Vice-President, Vernon W. Padgett of Alleghany; Secretary-Treasurer, Robert A. Peers of Colfax. Delegate, William M. Miller of Auburn; Alternate, C. C. Briner of Auburn.

On November 1 and 2, four members of our society attended the Postgraduate Conference of the Eighth Councilor District, which was held at Chico on those dates.

Our membership appreciates very much the support and guidance furnished us by the staff of the central office, and also by our Councilor for the Eighth District, Dr. Frank MacDonald of Sacramento.

Robert A. Peers,
Secretary.

Sacramento Society for Medical Improvement

The Sacramento Society for Medical Improvement meets on the third Tuesday of each month at the auditorium of the Sutter Hospital at Twenty-ninth and L streets at 8:30

p. m. No meetings are held during the vacation months of July and August. The programs are arranged by a committee, and the December meeting is devoted to Society business and the election of officers for the ensuing year. General meetings of the Society during the past year have been as follows:

January 21—"Nontuberculous Lesions of the Chest," by Dr. A. Peers, Colfax.

February 18—"Newer Developments in Urologic Surgery," by Dr. Oswald Swinney Lowsley, New York, Director of James Buchanan Brady Foundation, New York Hospital, New York, N. Y.

March 15—Seventy-third annual banquet at the Sutter Club.

April 15—"Shock," by Dr. J. B. Harris of Sacramento.

May 20—"Studies in Human Fertility," a motion picture by courtesy of Ortho Products, Inc.

June 17—"Recent Advances in the Study of Convulsions," by Dr. Theodore Fender, Associate Professor of Neurosurgery, Stanford Lane Hospital, San Francisco.

September 16—"Visible Cancer: Breast and Pelvic," by Dr. Henry J. Ullmann of the Santa Barbara Cottage Hospital, Santa Barbara.

October 21—"The Current Status of Coccidioidal Infection," by Dr. Charles Edward Smith, Professor of Preventive Medicine, Stanford University; "A Basic Science Law for California," by Ben H. Read, Executive Secretary, the Public Health League of California.

November 18—"The Treatment of Burns," by Dr. George Warren Pierce of San Francisco.

There are 159 active members in the Society. Five new members have been elected to date, and ten are due for election before the end of the year. There is one retired member. No members have been dropped, and on November 15 Dr. L. C. Barrette was lost by death. Eleven members are in active military service and have been exempted from local dues.

No bulletin is published by the Society, the meeting programs being announced on printed notices which are sent to all local physicians whether or not they are members of the Society. Regular notices of the meetings are also sent to the physicians in military service at the adjacent Army posts.

The second Postgraduate Conference of the Eighth Councilor District was held at Chico on November 1 and 2, and was well attended by members of the Sacramento Society for Medical Improvement.

The Medical Grievance Committee has done much to encourage a better understanding between the members of the profession themselves, and between the members of the profession and patients. The Committee on Public Relations has helped promote harmony between the state and city health officers and the local profession.

The Legislative Committee has done excellent work in promoting the passage of several important measures through the State Legislature and in obtaining unfavorable action on those measures which were considered inimical to our welfare. At present the interest of the Committee is centered on the proposed Basic Science Initiative in order that the citizens of our district will look with favor upon it.

The Woman's Auxiliary meets on the same evenings as the County Society, and has been extremely coöperative in all the activities of the Society pertaining to the promotion of desirable public health and social welfare work.

CURTIS H. MCDONNELL,
Secretary.

Shasta County Medical Society

Seventeen physicians hold membership in the Society, three being in military service. The dues of such have been exempted.

Meetings are held, except during June, July, and August, at Redding. Attendance is good.

Postgraduate Conferences are held in conjunction with other component societies.

In this county the reaction concerning the Basic Science Law is in question.

Our County Hospital accepts pay patients only in cases of emergencies, or for isolation purposes.

JULIUS M. KEHOE,
Secretary.

Tehama County Medical Society

The Tehama County Medical Society has an active membership of ten physicians.

Our society usually meets in Red Bluff, on call by the President. No branch of the Woman's Auxiliary has been established in our county.

Citizens are admitted for treatment at the Tehama County Hospital, and regular fee tables have been established.

R. G. FREY,
President.

Yolo County Medical Society

During this past year, first in the history of the Yolo County Medical Society, the item of chief importance seems to have been one of change in personnel.

The Society began one year ago with twenty members, including one in active military service. Since that time we have taken in four new members—one residing in an adjacent county; three members have entered active military service, making a total of four engaged in the armed forces; one member has retired from active practice; one member is moving to another county shortly; and five physicians have recently been licensed to practice in Yolo County—all of whom anticipate membership in this society as soon as residence requirements are satisfied.

Therefore, out of a total of thirty physicians licensed to practice in Yolo County, twenty-eight are either active members of our society, are members in active military service, or intend to become members as soon as residence requirements permit. Neither of the remaining two nonmember licentiates conducts a full-time active medical practice.

New members admitted were: Doctors L. S. Goerke, Yolo County Health Officer; J. Porter of Yolo County Hospital, M. P. Stansbury of Vacaville (Solano County), and M. N. Wilmes, otolaryngologist at Woodland Clinic.

One-sixth (17 per cent) of the membership has entered active military service. Members having joined the armed forces (and exempted from local Society dues) are: Doctors J. W. Rovane from the Yolo County Hospital, L. S. Goerke, M. N. Wilmes, and H. S. Graeser of Woodland.

Newly arrived physicians awaiting fulfillment of residence requirements are: Doctors G. Babbin of Yolo County Hospital; R. Burns, urologist at Woodland Clinic; D. Frost, newly appointed Yolo County Health Officer; J. Gray, ophthalmologist at Woodland Clinic, replacing C. K. Mills (who is planning to move to Modesto); and A. E. Leivers, otolaryngologist at Woodland Clinic.

Special tribute should be paid to Dr. Fred Fairchild, widely known surgeon on the Woodland Clinic Hospital staff, who retired from active practice on July 1 of this year. He has served the profession well during his many years of practice, and fully deserves his retirement, intending to operate a buzz-saw at his home—a favorite hobby.

Meetings have been held once monthly in Woodland (except during July and August) on the first Wednesday evening. The attendance has averaged 72 per cent, exclusive of members away on military duty. It has been our policy to have some outside speaker, usually a specialist, talk at each meeting. A special Postgraduate Committee has been considered unnecessary for our small group, our programs being arranged by a committee composed of the president, vice-president, and secretary.

Among items of business recently taken up are the passage of an amendment to the by-laws providing for a Grievance Committee, the circulation of Basic Science Initiative petitions by individual members, and the formation of a coördinating committee for California Physicians' Service.

We feel that the Yolo County Medical Society's first year has been a success, and trust that our group will enjoy continued success in the future.

WILFRED T. ROBBINS,
Secretary.

Yuba-Sutter-Colusa County Medical Society

As secretary of the Yuba-Sutter-Colusa County Medical Society, it is with reluctance that I submit the following report:

It seems that members of our society have been too busy individually to take the necessary interest in the problems of the Society attendance during the year, in spite of the fact that we had some very fine programs which were adequately advertised; and this has been the poorest in the past eight years.

Only one member was present at every meeting—Dr. R. Lucian Hamilton, who will shortly be a medical officer in the Army.

Two members missed only one meeting—Doctors Stanley R. Parkinson and Leon M. Swift.

Two members also have the honor of having attended no meetings during the year.

The Yuba-Sutter-Colusa County Medical Society's membership is twenty-five. Of this number, only twenty-two are active members.

At the beginning of the year, President Whitney appointed eleven committees, but only two have been working. The Hospital Relations Committee for the Yuba County Hospital (details of the set-up have been previously reported in CALIFORNIA AND WESTERN MEDICINE) and the Program Committee, which has worked especially well to provide interesting, educational programs, as follows:

January 7—Doctor Beach of Sacramento spoke on "Traumatic Injuries to the Genito-Urinary System," illustrating

his paper with lantern slides and x-ray films. Doctor Seltzer, also of Sacramento, spoke on "Closed Abdominal Injuries and Autotransfusion." These papers were formally discussed by Dr. Joseph E. Tillotson of Colusa.

February 4—Dr. R. Lucian Hamilton showed colored motion pictures on Plastic Surgery for Dupuytrens; Herniоplasty; and Transverse Cervical Cesarean Section.

March 4—Dr. George Warren Pierce spoke on "Recent Advances in Reconstructive Surgery," and limited his lecture to cases in which burns were the etiologic factor; slides and motion pictures were shown. The Secretary gave a full report of the meeting of the annual Secretarial Conference, which he attended in San Francisco on February 22.

At the April, May, and June meetings, Dr. R. Lucian Hamilton showed films on Regional Anesthesis; Skin Grafting; Goiter Surgery; Repair of Cystocele and Rectocele; Total Hysterectomy; and Nephropexy. Dr. Stanley R. Parkinson reported on the State Medical Convention.

October 8—Army medical program arranged by Chairman Hamilton: "Aviation Medicine," discussed by Lieutenant Anthony M. Fratis; "Problems of Military Surgery," paper by Captain George C. Shivers; "The Army and Its Problems as I See Them," by Major Harold R. Hennessy; "Army Impressions," by Lieutenant Benjamin F. Miller.

November 12—Dr. Garnett Cheney was the guest speaker, who spoke on "Present-Day Management of Diarrheal States."

Of interest was a motion that instructed the Secretary to send a check for $50 to the National Physicians' Committee. This check was mailed immediately.

The Yuba-Sutter-Colusa County Medical Society will have a meeting on December 10, at which time the officers for 1942 will be elected.

LEON M. SWIFT,
Secretary.

NINTH DISTRICT

Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma, and Trinity Counties; John W. Green, Vallejo, Councilor.

Humboldt County Medical Society

For the year 1941 the Humboldt County Medical Society has a paid-up membership of thirty-four. One of our members, Dr. Edgar Holm, died during the year, and three of our members—Doctors John S. Chain, Charles C. Falk Jr., and David N. McInturff, Jr.—are in active military service. Two physicians who have moved into the county—Dr. Fred Herzer of Garberville and Dr. Max Todd of Eureka—have applied for membership. Dr. Nathan Wasserman, a specialist in ear, nose and throat, has expressed a willingness to join our society as soon as he meets the six months' residence requirement.

Eight meetings were held during the year. One of these was a joint meeting with the Woman's Auxiliary. Outside guest speakers addressed three of our meetings. Several good sound moving-picture films on medical and surgical subjects were shown at other meetings.

Educational programs before lay groups, on cancer and tuberculosis, were sponsored by our society. Speakers furnished by us were: Doctors W. J. Quinn, Lane Falk, O. R. Myers, M. J. Goodman, Morris Krutchkoff, Fred Olson, Harry Jenkins, and J. S. Woolford.

Our society put on an educational exhibit at the Humboldt County Fair in Ferndale this year. Dr. Morris Krutchkoff was chairman of the County Fair Committee, and was assisted by Doctors L. G. Kramar, Fred A. Olson, J. M. Brown, and J. S. Woolford. Plans have been made to provide space in a permanent building for a yearly exhibit of this type.

Mr. Frank O. Erwin of the Intercoast Hospitalization Insurance Association started the sale of California Physicians' Service in this area, and has signed up a number of groups. The people of this section are familiar with sickness insurance because of the Union Labor Hospital and Medical Service tickets, which have been on sale for over thirty years, and because of similar services offered by the large lumber companies to their employees.

Dr. Lowell G. Kramar of Fortuna served us as president during 1941.

J. S. WOOLFORD,
Secretary.

Marin County Medical Society

The Marin County Medical Society has now forty-three active members, with four additional in the Service. One member dropped out. Three new ones came in. None have left the county or died.

This county is remarkably free from cults. We have two osteopaths and several chiropractors, but very little is heard from any of them. There are no clinics in the county.

The County Society has held eight meetings this year, with an average attendance of sixteen. There were always guests present. The meetings have been held at Deer Park Villa, Fairfax, but a change is contemplated for next year.

Several of the members have taken postgraduate courses during the past year, but not in relation to the Society.

The Woman's Auxiliary has continued to function very well. The ladies always have a separate program and there is usually a good attendance. We expect them to keep up on good work, as they always help to bring the doctor husband to the meeting, where all come to be better acquainted.

CARL W. CLARK,
Secretary.

Mendocino-Lake County Medical Society

The number of active members in our society for this year is thirty. There was one transfer to another county unit, but we have two new members. Three members of the County Society are now in military service—two in the Army and one in the Navy. The Society has exempted these members from local dues.

In Mendocino and Lake Counties we have forty-one doctors of medicine who are licensed to practice; also one drugless practitioner.

The area of Mendocino County and of Lake County is so great that we find it inadvisable to hold more than four meetings a year. These meetings are conducted in different parts of the two counties each time, and are attended by twenty to thirty members. Our programs usually comprise a guest speaker, medical motion picture, or a round-table discussion. The wives of the members are invited to attend one of the yearly meetings.

Among some of our guest speakers of the past year were Dr. Leonard Hines of Santa Rosa, who spoke on "Hospital Care: The Responsibility of the Physician"; and Dr. Guy Trimble of Oakland, who discussed "Pulmonary Tuberculosis." Mrs. Howard R. Madeley of Vallejo spoke to the members of the Society on September 6, concerning the Woman's Auxiliary to the California Medical Association.

Dr. Henry Rogers and Dr. Dwight Murray have been the guests of the Society, and have ably discussed problems of the State Association.

Meeting notices, consisting of a mimeographed quarterly bulletin, are mailed to the members.

It is planned to hold a postgraduate conference early in 1942.

A Grievance Committee has been appointed by the Society, and a by-law has been adopted for such a committee.

At the next meeting of the Society, on December 15, the wives of the members are to assemble to discuss the formation of a Woman's Auxiliary.

OTTO L. GERICKE,
Secretary.

Napa County Medical Society

Napa County Medical Society has just completed another successful year. This year we have the prospect of, and have taken in, six new members, all newcomers to the county.

Our monthly meetings have been based on refresher-type lectures by outstanding men from the Bay area, on various topics.

At the last monthly meeting, held at the Veterans' Home in Yountville, L. E. Charlesworth, was elected president; Walter H. Brignoli, vice-president; M. M. Booth, secretary-treasurer; Dwight H. Murray, delegate; and Allan K. McGrath, alternate.

In December we anticipate having the usual Christmas party which annually is devoted to a good time and is, as usual, nonscientific.

M. M. BOOTH,
Secretary.

Siskiyou County Medical Society

During the past year our society has had seventeen members. One is in military service. We have exempted from local dues members who have gone into military service.

Six meetings were held during the year 1941, these being on call. Four of these meetings took the nature of clinical conferences. Two meetings were given over to questions of organization and legislative matters. Officers of the State Society were among the guest speakers.

Among the guest speakers on scientific topics were Dr. Cabot Brown of San Francisco, Dr. B. M. Palmer of Oakland, and Dr. Karl Meyer of San Francisco.

No action has been taken concerning the appointment of a grievance committee. In our county the proposed Basic Science law will probably receive approval.

We do not maintain a branch of the Woman's Auxiliary.

VICTOR W. HART,
Secretary.

Solano County Medical Society

Solano County now has sixty licensed physicians and surgeons, who may be classified as follows: Active members of Solano County Medical Society, 35; honorary members (on retired list), 2; active nonmembers, most of whom have been in the county a short time only, 9; full-time public health officer, 1; retired physicians, 8; licensed United States naval officers who do not practice privately, 7.

In addition to these, the County Society has recently lost one of its members of twenty years' practice in Vallejo in the death of Dr. Paul H. Reilly.

The Solano County Medical Society meets on the second Tuesday evening of each month, usually at the Casa de Vallejo Hotel, in Vallejo. We have a meeting each month, except July or August, making eleven meetings in each year. In July, each year, a four-county meeting is held, representing Marin, Sonoma, Napa, and Solano Counties.

We are particularly fortunate in having the Mare Island Naval Hospital within our bounds. The staff of the Naval Hospital coöperate with the County Society in taking an active part in our programs and social gatherings; and usually in June, each year, they entertain the Society, furnishing the program, which takes the place of our regular June meeting. In this connection, we want to express our sincere appreciation to the commanding officer, Captain C. J. Holeman; the former executive officer, Captain R. G. Davis; and the present executive officer, Captain A. H. Dearing, for their many courtesies, kind coöperation and active participation in the work of the Solano County Society during the year just passed, despite the added load placed on them by the greatly increased defense program.

The Solano County Medical Society has two of its members in active military service. The Society exempts such members from local dues.

The Society has a Grievance Committee which is functioning. The Society has amended its by-laws to conform to the adopted standards for medical defense purposes.

The Society has no headquarters at present and no immediate plans for the same. We have no library and no regular bulletin, notices being mailed out from the Secretary's office. We have not held any postgraduate activities on account of our proximity to San Francisco programs.

A Speakers' Bureau has been organized and has coöperated with and met the requests of the Woman's Auxiliary to the Solano County Medical Society, which has been quite active along the lines of medical education, civilian defense, and various Red Cross enterprises. It has also taken an active part as a distinct entity in promoting civic betterment in this crowded defense area. The latest of endeavors in which it has coöperated has been the putting over, in four days, a civic music organization.

The Solano County Hospital does not accept pay patients, except contagious diseases, requiring hospitalization and isolation. The superintendent, Dr. Felix Rossi, is an active member of the Solano County Medical Society.

Our members support the California Public Health League. The Society makes an annual contribution to the National Physicians' Committee for the Extension of Medical Service. Several of our members also individually contribute to the support of this organization.

The Solano County Medical Society has an active Legislative Committee. The Society is under no obligations to any newspaper, but proper contacts have elicited coöperation, and a change in the attitude of the newspapers to the Society and its accomplishments is very much in evidence.

During 1941, no meetings have been held with any other professional group, except that the members of the Solano County Nurses' Association were the guests of the Medical Society at the October meeting.

The programs of the Society's regular meetings are arranged by a committee, of which Dr. A. J. Ryan is chairman. They have brought us interesting programs throughout the year.

On January 14, Dr. Garnett Cheney spoke on the topic, "The Post-Influenzal State." The discussion was carried on by Dr. Henry Rogers, Capt. C. J. Holeman of the Naval Hospital, Dr. D. H. Murray of Napa, Capt. R. G. Davis of the Naval Hospital, and several local members.

On February 11, Dr. Karl Schaupp of San Francisco addressed the Society on "The Menopause: Cause, Diagnosis, and Treatment." The discussion was led by Dr. Theodore Weller and Dr. Eugene Kleeman, Jr., of Oakland.

On March 11, Dr. C. T. Hayden of the University of California Hospital, talked on "Modern Prenatal Care: A Factor in the Reduction of Mortality." Dr. Chester Cooley of the French Hospital staff, San Francisco, led the discussion of Doctor Hayden's subject.

On April 8, Dr. Albert Rowe of Oakland and San Francisco presented to us "The Modern Concept of Bronchial Asthma: Its Diagnosis and Treatment." Doctor Rowe gave a masterful outline of the subject of allergy, punctuated by the use of slides. Dr. William Deamer of the University of California Hospital led the discussion.

The evening of May 13 brought Doctor Overstreet from the University of California staff to give us the benefits of the mass of information he had collected on "Vitamin K and Its Use in Obstetrics." He took up the story of vitamin K from the time its function was first recognized before the product was isolated and brought it down to its successful application to modern obstetrics, furnishing statistics (some of which as yet unreleased) to back up his statements. Doctor Lyons, also from the University of California staff, led the discussion, which was freely indulged in by many of the local men.

On June 17, the staff of the United States Naval Hospital, under Captain C. J. Holeman, entertained Marin, Sonoma, Napa, and Solano County Medical Societies, together with representatives from Letterman General Hospital, Stanford University Hospital, Medical Corps of the Twelfth Naval District, and various defense units of the Bay district. Over two hundred visiting physicians enjoyed a chicken dinner long to be remembered, followed by a professional program led by Captain Reed of the Twelfth Naval District. Our president of the California Medical Association, Dr. Henry Rogers, made a short talk, reporting on the American Medical Association meeting in Cleveland. Doctor Dearing gave the main paper of the evening, presenting the medical aspects of the invasion of foreign territory by water, tracing the various steps in the development of such a campaign up to the organization of a base hospital on foreign soil.

On July 1, a business meeting was held. Several matters of policy in handling the work of the County Medical Society were discussed. Among the topics considered and acted upon were: Coördinating Committee for California Physicians' Service; Committee on Industrial Health; and Civilian Defense.

On July 22, Solano County Medical Society entertained the officers of the California Medical Association, State Senators, Assemblymen, Superior Judges, Supervisors, and medical societies of Marin, Sonoma, and Napa Counties. The evening was purely social, and the 112 who attended felt that it was worth while.

On September 9, Dr. William B. Faulkner of San Francisco spoke to us on "Injuries of the Chest of Interest to the General Practitioner." This was an extremely interesting talk, and gave us the benefit of much recent work done in the treatment of the severe grade lesions.

At the October meeting, Dr. Frank Hand of San Francisco took up the "Complications of Upper Respiratory Infections." Discussion of this very interesting paper was indulged in by Dr. Malcolm Johnson, Captain Holeman, Doctor Marquette and Doctor Hilt of the United States Naval Hospital.

F. Burton Jones,
Secretary.

* * *

Sonoma County Medical Society

Last year's membership was increased by the addition of seven new members, the total membership now consisting of seventy physicians. Three of our members are in military service. Military members are exempted from the payment of local dues.

Meetings were held monthly, except during July and August. The programs consisted of presentations by guest speakers and local members. In June the annual conference and dinner with members of the dental, pharmaceutical, and legal professions was held.

The reaction of citizens to the proposed Basic Science Initiative has been favorable.

The Woman's Auxiliary continues to carry on excellent work.

At the Sonoma County Hospital, thirty-five members of our society are on the attending staff. The County Hospital accepts part-pay patients. In connection with the County Hospital, five out-patient dispensaries are operated in the following places: Sonoma, Petaluma, Santa Rosa, Sebastopol, and Healdsburg.

The Society presents radio programs over Station KSRO on each Tuesday.

John O. Raffety,
Secretary.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (17)

Alameda County (2)

Robert T. McMahon, *Albany*
John J. Phillips, *Alameda*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

Los Angeles County (8)

W. W. Altig, *Long Beach*
Herschel H. Burston, *Los Angeles*
Cirino Finocchiaro, *Los Angeles*
William Gordon Garnett, *Pasadena*
Howard H. Groskloss, *Compton*
Jack Nichols, *Los Angeles*
Esther B. Sturgeon, *Los Angeles*
Richard V. Tysdale, *Los Angeles*

San Bernardino County (2)

G. John Leonard, *Twenty-Nine Palms*
Russell T. Smith, *Loma Linda*

San Diego County (2)

Edwin G. Kirby, *San Diego*
George M. Plagens, *San Diego*

Santa Barbara County (2)

Charles J. Betlach, *Santa Barbara*
Wray J. Tomlinson, *Santa Barbara*

Sonoma County (1)

William J. Rudee, *Santa Rosa*

Transfers (3)

Joel M. Gibbons, from San Bernardino County to Ventura County.

Malcolm C. Johnson, from San Francisco County to Solano County.

John N. Stewart, from Ventura County to Santa Barbara County.

In Memoriam

Fearon, William Max. Died at Los Angeles, October 11, 1941, age 52. Graduate of College of Physicians and Surgeons, Los Angeles, 1913. Licensed in California in 1913. Doctor Fearon was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✝

Harter, Thomas Hudson. Died at Pasadena, October 20, 1941, age 51. Graduate of the University of Pittsburgh School of Medicine, Pennsylvania, 1914. Licensed in California in 1926. Doctor Harter was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✝

Holbrook, Edward Ferris. Died at San Francisco, October 9, 1941, age 70. Graduate of Cooper Medical College, San Francisco, 1893. Licensed in California in 1894. Doctor Holbrook was a member of the San Francisco County Medical Association, the California Medical Association, and the American Medical Association.

✝

Reilly, Paul Heron. Died at Vallejo, October 7, 1941, age 77. Graduate of Cooper Medical College, San Francisco, 1901. Licensed in California in 1901. Doctor Reilly was a member of the Solano County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

OBITUARY

Ellen Smith Stadtmuller
1883–1941

Ellen Smith Stadtmuller, for nearly twenty years Chief of the Bureau of Child Hygiene of the California State Department of Public Health, died at Children's Hospital, San Francisco, Tuesday afternoon, November 25, 1941. She had been ill for more than six months, but was able to resume her work a few weeks before her demise.

Member of a pioneer San Francisco family, Doctor Stadtmuller spent most of her life in the city of her birth. She received her A. B. degree from Stanford University in 1907 and a degree in medicine from the University of California Medical School in 1912. She was licensed to practice medicine in California during the same year and for ten years was engaged in private practice in San Francisco. During that period she was an instructor in pediatrics at the University of California Medical School and medical officer at the San Francisco State Teachers' College. She also served as visiting physician to the San Francisco Nursery for Homeless Children and was on the staff of Children's Hospital.

Her appointment as Chief of the Bureau of Child Hygiene came in 1922 and during her service in that position the state infant mortality rate fell from 71.1 in 1922 to 39.4 in 1940. She was largely instrumental in the development of a state-wide interest in pediatrics and maternal hygiene and secured the coöperation of hundreds of Californian physicians in the maintenance of local conferences where local underprivileged children receive physical examinations. Her passing leaves a distinct void among women practitioners of medicine in California, as well as in the nation-wide group of progressive women who have battled for the advancement of standards in maternal and child hygiene.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. HARRY O. HUND.....President
MRS. RENE VAN DE CARR.....Chairman on Publicity
MRS. ROSSNER GRAHAM.....Asst. Chairman on Publicity

News Items

Alameda County has planned a very full meeting for November. As has been the custom, new members are honored at this meeting, with a special luncheon table and each one is introduced at the beginning of the meeting.

Dr. Frank R. Makinson, Alameda County Chairman of the Public Health League, will explain fully the Basic Science Law. Questions will be in order, and petitions regarding this law are to be sent to each Auxiliary member.

Dr. Ira O. Church, Assistant Medical Director and County Health Officer of Alameda County, will give a talk on *Trends in Public Health.*

* * *

The first meeting of the Fresno Auxiliary on October 7 was honored by the presence of the state president, Mrs. Harry O. Hund. A dinner was held at the Omar Khayyam, about thirty-five members attending. Later, at the University Sequoia Club, Mrs. Hund spoke on the responsibilities of the Auxiliary and outlined the program for the year.

† Reports of county chairmen of publicity should reach Mrs. Rossner Graham, Assistant Chairman of Publicity, 6101 Acacia, Oakland, by the tenth of the month previous to publication. Address of the Chairman of Publicity: Mrs. Rene Van de Carr, 51 Prospect Road, Piedmont. For roster of state and county officers, see page 6, in front advertising section.

Mrs. Hund was welcomed by the president, Mrs. J. R. Walker, who presented the members of her board: Mrs. A. E. Anderson of Fresno, second national vice-president; Mrs. Kenneth Staniford, chairman of cancer control of California; and Mrs. Alto Diedrich, member of the Nominating Committee.

The business meeting was followed by a delightful book review, "How Many Heroes Are You?"

* * *

Mrs. Samuel P. Burre was hostess to the Humboldt County Auxiliary which met at her home on November 3.

Guest speaker of the evening was Mrs. Alice Osborne, attendance officer to the Eureka public schools. Mrs. Osborne gave a most interesting résumé of the splendid work accomplished by her T. S. L. Girls' Club, the initials being for Tolerance, Service, and Loyalty. Just a year ago, seven girls met with Mrs. Osborne to form a club for underprivileged senior and junior high school girls who were not affiliated with other clubs or organizations. During the first year fifty-three girls attended meetings, but due to national defense employment, many parents of the girl members moved away, diminishing the membership to twenty-two. The present club members expect to build up to an active roll call of fifty-five members before the year is ended.

Mrs. Osborne's address was an incentive for the Auxiliary to do something for these girls. It was decided that they be given a Christmas party, the date to be announced later.

* * *

The regular luncheon meeting of the Los Angeles County Auxiliary was held at the Women's Athletic Club on October 28.

Mr. Kenneth Roberts, magazine and newspaper correspondent, gave an interesting and enlightening talk on *Let's Face South,* dealing with Pan-American relations as he studied them on his recent visit to South America. He spoke about the alarming results of the inroads of German influence and penetration of that country.

Honored guests were officers of the Los Angeles County Medical Association. Many of the one hundred Auxiliary members present offered to "adopt" two draftees for Saturday, November 22. These boys will be guests of the city and county of Los Angeles for that week-end, and it is planned that the women call for them at their camp in Exposition Park and take them on a tour of the city and then home to dinner, and finally return them to camp in the evening.

* * *

The Woman's Auxiliary of Marin County met at Deer Park Villa on October 23 for the usual dinner meeting. There were twenty members and five guests present. The guests were wives of medical men living in the North Bay area and who are connected with national defense.

Mrs. John Taylor, first vice-president, presided in the absence of Mrs. Harry Hensler, President. The Auxiliary donated money to purchase two blood plasma kits for the British blood bank.

At this meeting, the state president, Mrs. Harry O. Hund, who is also one of the members of the Marin Auxiliary, talked about the many projects of the State Auxiliary, advising members to keep in close touch with all the various lay organizations in the community and also to assist with the work of the Basic Science Law.

Dr. Leo L. Stanley, who is the author of a recent book, "Men at Their Worst," told of his work in San Quentin and reviewed the history of that institution from its beginning to the present time. He spoke of the present-day treatment of the physically and mentally ill, and showed how much treatment has progressed in the last decade.

The Monterey County Auxiliary held its regular meeting at Sade's Restaurant in Carmel on October 15. Lunch was followed by a talk on the Basic Science Law by Dr. Mast Wolfson of Monterey.

Forty-five members and guests were present. Bridge was enjoyed for the remainder of the afternoon.

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The San Diego County Auxiliary held its October meeting at the University Club on the 14th. It was announced that the next month's meeting would be the annual bridge benefit, the proceeds to be used for the Benevolence Fund.

The meeting was turned over to Dr. C. W. Hartsough, who gave an interesting and amusing discussion on *The Common Misconceptions of Mental Hygiene.*

A very active year has been planned for participation of members, their friends, and the wives of visiting or military physicians.

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November 5 was a great day for the members of the San Francisco Auxiliary when they responded 100 per cent in entertaining men in the service at the San Francisco Hospitality House. At least one thousand men were served sandwiches, doughnuts, coffee, and punch.

In the afternoon, daughters of members acted as junior hostesses and helped to entertain the men by dancing and playing cards. In the evening the girls from the training schools of Stanford and of the University of California acted as hostesses. It was an undertaking well worth while, and members who came to stay only a few minutes remained for hours to help make the day a success.

The regular meeting was held on October 21, with Miss Beatrice Carpenter as the speaker. Miss Carpenter is chairman of the Food and Nutrition Section of the Home Economics Section of the Bay area. Her subject was *Nutrition for Defense.*

Miss Carpenter stated that today 40 per cent of the people of America are undernourished, and that this group does not necessarily mean the lower income groups, but that ignorance of food values makes people lack the vital foods which are essential in life itself. Her talk was full of interest on this subject and she suggested that a study of food values is essential to a healthy people and that one's own doctor is capable of prescribing a healthful diet which is, incidentally, a short cut to the necessary information.

* * *

The San Mateo Auxiliary opened its season with a tea at the Hillsborough home of Mrs. Olin Holmes on September 30. Eligible prospective members, as well as regular members were invited to attend.

Following a Board meeting on October 17 in the social hall at Gunst Park, Mrs. Ruth Close, Executive Secretary to the San Mateo Tuberculosis and Health Association, spoke on *Health, the First Line of Defense.*

Mrs. Close proposed the following project to the Auxiliary: "In the light of the findings of the million of rejected selectees, it would be in keeping with good public health service to look into the health of the future citizens of San Mateo County."

More than seventy members of the San Mateo County Medical Society and the Auxiliary attended the annual joint banquet of the two organizations on October 21 at the Benjamin Franklin Hotel.

Dr. Leo L. Stanley, chief surgeon at San Quentin prison, explained the medical set-up and cited improvements which have been made in the more than twenty years he has been physician there.

* * *

On November 3, the Santa Clara County Auxiliary held its second meeting of the year at the home of Mrs. Donald Threfall in San Jose. Mrs. Harry O. Hund, State Presi-

dent, attended the meeting and spoke to the gathering, stressing the need of coöperation among Auxiliary members for the work on the defense program.

Plans were made for a membership tea to be given in December, each member being responsible for bringing one new members to the tea. Tentative plans were made to put on a dinner for a group of soldiers from Moffett Field.

Mr. Jack Green presented a very interesting program based on the subject of art and music, displaying many famous paintings as well as entertaining the audience with several piano solos. Tea was served by the Hostess Committee.

* * *

A busy season is beginning with the Santa Cruz Auxiliary. The first meeting honored Mrs. Harry O. Hund, State President.

Invitations have been issued for Army doctors' wives in the community and to all other eligible wives to join the organization. The Auxiliary voted a sum of money to the State Benevolence Fund, and started the wheels in motion for defense work.

CALIFORNIA PHYSICIANS' SERVICE†

Beneficiary Membership

September, 1939	1,220
March, 1940	9,322
September, 1940	17,398
March, 1941	24,107
September, 1941	30,215
October 31, 1941	32,027

On December 1, 1941, a considerable number of the new surgical benefit contracts will become effective. Since the benefits under this are so different from anything we have previously offered, a word of explanation to physicians seems in order.

1. Surgical plan members will carry a green identification card.

2. The dependents of the member will carry a white card with a distinguishing green stripe.

It should be noted that California Physicians' Service defines dependents eligible for service under the surgical contract as "the spouse and the unmarried children over the age of thirty days and under the age of nineteen." No other relatives, even though they may be financially dependent upon the employed member and living in the home, are included in the "Family Contract."

3. Definition of surgical services:

The terms "surgical services" and "operative procedures" as used herein include procedures involving cutting, incision or manipulation under anesthesia, local or general, but do not include the use of needles, cannulas or trochars, catheters or any fluid-carrying instrument or apparatus for the withdrawal of blood or other fluid, normal or abnormal, or tissue or the injection of any substance either for diagnostic or therapeutic purposes nor do they include the use of instruments or apparatus designed for the visualization of hollow organs or body cavities.

"Surgical Services" which are within the benefits of this contract are all operative procedures for the treatment of illnesses and injuries, including fractures and dislocations.

4. There is a one-year waiting period for herniotomy, tonsillectomy, adenoidectomy and nasal septum operations.

5. Any condition requiring surgery is covered, even though it may have been present before membership was acquired. This does away with the so-called "preëxisting" clause. (It is to be remembered that this applies only to the surgical contract.)

6. *X-Ray:* California Physicians' Service is only responsible for diagnostic x-ray if and while the member is a *registered bed patient in a hospital.* X-ray therapy is not included.

7. *Laboratory:* Again California Physicians' Service is only responsible if and while the member is a *registered bed patient in a hospital.* And, *furthermore,* these are specifically limited to ordinary clinical laboratory services, *i. e.,* urinalysis, blood counts, coagulation time and smears. This will mean that California Physicians' Service will not be responsible for such procedures as blood chemistry, cultures, or pathological examination of tissues.

8. The above provisions are important to remember, since under the surgical contract physicians may not bill California Physicians' Service for any x-ray and laboratory work performed in their own offices.

9. Questions which may arise regarding benefits under the surgical contract should be referred to the California Physicians' Service offices in Los Angeles or San Francisco.

† Address: California Physicians' Service, 153 Kearny Street, San Francisco. Telephone EXbrook 0161. A. E. Larsen, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

Overdosage with Sulfathiazole Causes Man's Death. Apparently the first death due to sulfathiazole overdosage, illustrating the hazards of self-medication and the ignoring of a physician's orders, is reported by Doctors Archibald L. Hoyne and Granville W. Larimore of Chicago in *The Journal of the American Medical Association* for October 18.

"Our patient," they say, "was one in whom acute agranulocytic angina [absence of the granular white blood cells] with a fatal termination followed the taking of sulfathiazole over a comparatively long period of time."

The history of the case is as follows: "A white man, aged thirty-four, was sent to the Municipal Contagious Disease Hospital on March 9, 1941, with a diagnosis of laryngeal diphtheria.

"The history obtained from relatives was sudden onset with chills, fever, and sore throat. The sore throat became progressively worse, as did the general condition, until on admission to the hospital, which was the fourth day of illness, the patient was virtually moribund [at the point of death]. . . . It was stated that he had always enjoyed good health until January 9, 1941, at which time, fearing that he had contracted gonorrhea, he visited a physician and related a story of venereal exposure and vague genitourinary symptoms. 'There was no urethral discharge present.' The physician prescribed sulfathiazole. . . . The original prescription was for twenty tablets and instructions were to have it refilled only once.

"However, according to relatives, the patient was able to obtain additional supplies of the drug and continued using it in varying amounts, taking from two to eight tablets a day. . . . The patient [according to his relatives' estimates] took approximately 200 tablets . . . during a period of nearly two months.

"On admission the patient was fairly well nourished but somewhat dehydrated [deficiency of water in the body]. . . . The throat was moderately red and edematous [swollen]. . . . The lips and finger-nail beds were cyanotic [blue].

"Because of the labored respiratory effort the patient was placed immediately in an oxygen tent. Blood and intravenous [into a vein] fluids were administered. Death ensued nine hours after admission.

"At autopsy the gross pathologic findings, together with microscopic study of bone marrow sections, confirmed the diagnosis of acute agranulocytic angina."

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.†

California Medical Association, Hotel Del Monte, Del Monte, California, May 4–7, 1942.

American Medical Association, Atlantic City, June 8–12, 1942.

Forum on Allergy: Fourth Annual Conference, Detroit, Michigan, January 10 and 11, 1942.

The Platform of the American Medical Association

The American Medical Association advocates:

1. *The establishment of an agency of Federal Government under which shall be coördinated and administered all medical and health functions of the Federal Government, exclusive of those of the Army and Navy.*

2. *The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health, and the care of the sick on proof of such need.*

3. *The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.*

4. *The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.*

5. *The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.*

6. *In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.*

7. *The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.*

8. *Expansion of public health and medical services consistent with the American system of democracy.*

Medical Broadcasts.*

Los Angeles County Medical Association.

The following is the Los Angeles County Medical Association's radio broadcast schedule for the month of December, 1941:

Saturday, December 6—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, December 6—KFI, 9:45 a. m., The Road of Health.
Saturday, December 13—KFAC, 8:45 a. m, Your Doctor and You.
Saturday, December 13—KFI, 9:45 a. m., The Road of Health.
Saturday, December 20—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, December 20—KFI, 9:45 a. m., The Road of Health.
Saturday, December 27—KFAC, 8:45 a. m., Your Doctor and You.
Saturday, December 27—KFI, 9:45 a. m., The Road of Health.

Lectures on Psychiatric Syndromes.—Dr. Jacob Frostig, lecturer and research associate in psychiatry, University of California Medical School, San Francisco, is lecturing in Los Angeles at the Cedars of Lebanon Hospital on Tuesdays at 7:30 to 9 p. m. His subject is the "Differential Diagnosis of Psychiatric Syndromes." The course will continue for about four more months. Physicians are welcome.

American Medical Association Broadcasts.—*Doctors at Work*, the dramatized radio program broadcast by the American Medical Association and the National Broadcasting Company will go on the air for its second season, beginning December 6, 1941, from 5:30 to 6 p. m., Eastern Standard time (4:30 to 5 p. m., Central Standard time; 3:30 to 4 p. m., Mountain Standard time; *2:30 to 3:30 p. m., Pacific Standard time.*) The program will be broadcast on upward of seventy-five stations affiliated with the Red network of the National Broadcasting Company and will be heard from coast to coast.

Doctors at Work, a successful, serialized story broadcast last year, dealt with the experiences of a fictitious but typical American boy choosing medicine for his vocation and proceeding to acquire the necessary education and hospital training for the private practice of medicine. Interwoven with the personal story of young Dr. Tom Riggs and his fiancée, Alice Adams, was the romance of modern medicine and how it benefits the doctor's patients.

The new series of broadcasts will resume where last year's story left off, namely, with the marriage of Tom Riggs and Alice Adams, and the subsequent life of a young doctor and his wife in time of national emergency in a typical, medium-sized, American city.

The program will be produced under the supervision of the Bureau of Health Education of the American Medical Association, W. W. Bauer, M. D., Director. Scripts will be by William J. Murphy of the National Broadcasting Company, author of such successful radio productions as "Flying Time," "Cameos of New Orleans," "Your Health," "Medicine in the News," and last year's "Doctors at Work." The scripts will again be produced by J. Clinton Stanley, and the National Broadcasting Company orchestra will be under the direction of Joseph Gallichio as heretofore. Actors will be drawn from the well-known group of Chicago radio actors previously heard in American Medical Association and other successful broadcasts.

The program will be available to all stations affiliated with the Red network of the National Broadcasting Company. Announcements should be sought in local newspaper radio columns, under the title "Doctors at Work," or possibly "American Medical Association" or, in some instances, "Health Broadcasts." Evidence of local interest in the program may be the determining factor in whether a local station takes this educational, sustaining feature or sells its time to a local revenue-producing program. Physicians and friends may wish to write to local stations in commendation of the programs.

† In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Army's Social Disease Problem Laid at Door of Civilians.—Joseph Henry Jackson, in the San Francisco *Chronicle*, in The Bookman's Daily Notebook department, writes:

"Five years ago Dr. Thomas Parran was appointed Surgeon-General, United States Public Health Service.

"With that appointment began a movement like nothing that had ever taken place in the United States before—a definite, clear-cut effort to drag out into the light the taboo topic of the social diseases and to do something about stamping them out. To be sure, the United States was far behind Sweden, for example, which had brought its sick-per-thousand figures down to a small fraction of what they had been and what other countries, most of them, have long tolerated. But a late beginning was better than none. . . .

"Since then, the movement has made tremendous steps forward. Or perhaps it would be better to say that it had made great steps forward, until something else happened. That something else was the defense program, which involved putting a cross-section of America's young men into training camps.

"This necessary move has had tragic results in one direction. As a result of it, the downward curve of venereal disease has begun to climb again. Just how and why is the subject of the two most important chapters in a new book, 'Plain Words About Venereal Diseases' (Raynal & Hitchcock; $2), written by Surgeon-General Parran and his assistant, Dr. R. A. Vondelehr. Their frank and shocking revelations are of the utmost importance—put it on the hardest-boiled ground you like—to every single taxpayer who has to put out his money for the needless waste of man power and money these diseases are costing at the most critical moment in this nation's history.

"As the public knows, since September, 1939, our Army has been multiplied more than eight times. Of this 1,500,000 new men, the point to remember is that no recognized cases of venereal disease were accepted for service. . . .

"Reports showed the expected reduction at first. Then, regiment by regiment, the rates crept up. By March of 1940, for example, the rate was almost back up to 'normal.' With a new influx of men in June, 1941, the rate went down again. . . .

"Unpleasant as it is to think about, the fact is there. Approximately 600,000 young men, an average American cross-section of sons, have been called into the Army to become infected with just one of the venereal diseases. . . .

"Doctor Parran does not mince words. 'What is our most expanded war industry?' he asks. He gives the answer: 'Prostitution.' The girl-syndicates are busy as they have never been before, which, of course, though Doctor Parran doesn't bring up the point, means the revival in still more vicious forms of an old kind of gangsterism." . . .

* * *

To the above may be added the following figures relating to California, compiled from a recent United States Public Health bulletin:

ANNUAL RATES PER ONE THOUSAND POPULATION FOR SYPHILIS AND FOR GONORRHEA BY STATES
(Fiscal Year 1941)

State	Annual rates per 1,000 populaton *Syphilis*	*Gonorrhea*
California	3.3	3.0
Average (all states)	3.7	1.5

* * *

ANNUAL RATES PER ONE THOUSAND POPULATION FOR SYPHILIS AND FOR GONORRHEA BY CITIES
(Fiscal Year 1941)

City	Annual rates per 1,000 population *Syphilis*	*Gonorrhea*
Los Angeles	4.5	3.7
Oakland	2.5	2.3
San Diego	5.0	7.9
San Francisco	4.0	4.0
Average (all cities)	4.8	2.3

LOS ANGELES HEALTH DEPARTMENT VENEREAL CLINIC

Beginning Monday, November 3, 1941, new patients were admitted to the Southeast Polyclinic of the Los Angeles City Health Department at 5425 South Central Avenue, for consultation, advice and treatment for the venereal diseases.

This clinic is the finest of its kind in California. At a cost of $15,000 for reconstruction and equipment, the Bureal of Venereal Diseases of the State Department of Public Health and the City Health Department have cooperated to set up a health clinic which is entirely modern and to which we and the residents of the southeast district look with pride.

Clinic hours for new patients seeking tests or advice are as follows:

Tuesday—9 a. m. to 11 a. m.; 12:30 p. m. to 3:30 p. m.
Wednesday—12:30 p. m. to 3:30 p. m.
Friday—8 a. m. to 11 a. m.; 12:30 p. m. to 3:30 p. m.

The clinic is set up for child-hygiene conferences which have been in operation during the past month, and for venereal disease clinics which begin operation on November 3. Later, other health work will be established in the new quarters to round out the health program and provide good health service to the community.

Scientific Attack on Problems of the American Diet. "A higher level of nutrition for the better health of all Americans is an integral part of national progress," Mr. Swift pointed out in making the formal announcement. "To advance fundamental knowledge of foods and to discover or develop ways to feed our nation better and make our people healthier, happier, and more efficient, Swift & Company has undertaken to expand its support of nutrition research. The fellowships in nutrition are designed further to enlist the country's research talents and facilities in order to achieve the long-range objectives of the national nutrition program and the immediate aims of national defense." For further information, address Research Laboratories, Swift & Company, Chicago, Illinois.

California Tuberculosis Association.—This year tuberculosis associations in California will try for a goal of $520,000 in the annual Christmas Seal sale. Last year the Seal sale in California netted 6.7 cents per capita. Two states—New York and Pennsylvania—had larger gross returns than California. And Delaware came through with a per capita of 10.3 cents.

California's tuberculosis death rate is higher than that of the three states which led us last year in the Seal sale. Hence, the goal for this year is not set merely to beat our Eastern friends, but to meet a need which is greater this year than ever before. . . .

Christmas Seal funds may be used to encourage and promote the establishment and the support from public funds, or other sources, of services and facilities for case-finding, diagnosis, treatment and rehabilitation of the tuberculous. Such public services and facilities include diagnostic clinics directed by trained personnel and equipped with facilities for tuberculin testing and chest x-rays; institutions for the prevention and treatment of tuberculosis; public health nursing; medical social workers; counseling, training and placement of patients; provision for sheltered employment and prolonged medical and social follow-up of arrested cases after their discharge from sanatoria.

Where such services do not exist and no public funds are available for their establishment, contributions from Christmas Seal funds are permissible, provided liberal community participation is also assured. Transfer to public support must be made as soon as the value of these services has been accepted as a public responsibility.

Urology Award.—The American Urological Association offers an annual award "not to exceed $500" for an essay (or essays) on the result of some specific clinical or laboratory research in urology. The amount of the prize is based on the merits of the work presented, and if the Committee on Scientific Research deem none of the offerings worthy, no award will be made. Competitors shall be limited to residents in urology in recognized hospitals and to urologists who have been in such specific practice for not more than five years. Essays shall be in the hands of the secretary, Dr. Clyde L. Deming, 789 Howard Avenue, New Haven, Connecticut, on or before April 1, 1942.

Tularemia Season Is Here: Handle Rabbits With Care.—With the hunting season coming up, the American Red Cross warns nimrods to think twice before shooting the lackadaisical rabbit—it may carry the deadly tularemia germ.

Dr. Albert McCown, medical director of the Red Cross, points out tularemia not only threatens the hunter, but the housewife and market man, as well. He advises those handling habbits in dressing and cooking to wear rubber gloves. Happily, thorough cooking kills tularemia virus, removing possibility of infection.

To the hunter, Doctor McCown gives this advice: Avoid the listless rabbit that makes too easy a target; chances are it is diseased, more than likely with tularemia. Although the rabbit is the most frequent carrier of tularemia, other animals carry the disease. Opposums, muskrats, skunks, and other rodent-type animals often pick up the infection from wood ticks, he said.

Bulletin from the Pharmacological Laboratory of the University of California Medical School.—Calling attention to pharmacological items of potential interest to clinicians, the Bulletin states:

1. *Occasional Amusement for Busy Clinicians in Weekly Issues of Science:* B. F. Sieve (Science, 94:257, 1941) claims gray-haired humans blossom with marked darkening in about two months from twice daily oral ingestions of 100 milligrams of p-aminobenzoic acid. Sulfonamide should inhibit this. To the notions of S. Ansbacher (Science, 93: 164, 1941) and of P. Fildes (Lancet, 238:955, 1940) that p-aminobenzoic acid is a vitamin factor in the B complex, S. Wiedling adds evidence of its being essential to metabolism of all kinds of plants, and found in them (Science, 94:389, 1941). S. A. Peoples devises a method for continuous recording of the rate of oxygen consumption (*ibid.*, 373). A. A. Blanchard discusses the metal carbonyls which are so important in the theory of chemistry and which have such remarkable biological action (*ibid.*, 311). E. Witebsky and N. C. Klendshoj (*ibid.*, 256) describe with many references their isolation of groups specific carbohydrates from gastric juice for A, B, and O bloods, and the preparation of safe universal donor O blood by neutralizing anti-A and anti-B antibodies by 10 milligrams A and B specific substances in 10 cubic centimeters of physiological saline solution per 500 cubic centimeters of O blood. G. W. Thorn, L. L. Engel, and R. A. Lewis (*ibid.*, 348) show that while corticosterone and desoxycorticosterone greatly reduce urinary sodium chlorid excretion, 17-hydroxy-corticosterone and 11-dehydro-17-hydroxycorticosterone greatly increase it. This seems to explain why desoxycorticosterone therapy in Addison's disease produces edema, and indicates that potent adrenal cortex extracts contain a mixture of sodium retaining and sodium excreting factors.

2. *New Books:* C. K. Drinker and J. M. Yoffey, "Lymphatics, Lymph and Lymphoid Tissue," Harvard Press, Cambridge, 1941; this gives much of Dr. Drinker's Lane Lectures on the physiological and clinical significance of the lymphatic apparatus. S. L. Polyak, "The Retina," University of Chicago Press, 1941. D. Perla and J. Marmorston, "Natural Resistance and Clinical Medicine," Little Brown, Boston, 1941, a comprehensive, well-documented, and well-organized volume. J. T. Culbertson, "Immunity Against Animal Parasites," Columbia University Press, New York, 1941. A. Kardiner, "The Traumatic Neuroses of War," Hoeber, New York, 1941. G. W. Harley, "Native African Medicine," Harvard Press, Cambridge, 1941. G. W. Gray, "The Advancing Front of Medicine," New York, 1941, a clearly written canonical expression by an orthodox New York reporter. B. J. Stern, "Society and Medical Progress," Princeton Press, 1941, another canonical expression by a New York sociologist. S. and J. F. Flexner, "William Henry Welch," New York, 1941, neither a critical definitive biography nor an entertaining popularization, but something betwixt.

3. *Scandinavian Contributions:* N. Emmelin (Acta Physiol. Scand., 2:289, 1941) finds that evipal and other barbitals give atropin-like effects on autonomic system. H. Levi (*ibid.*, 311) describes a neat Geiger counter arrangement. T. Broman and D. Jacobsohn (*ibid.*, 324) find that cat's brain, 0.7-1.1 body weight 2.5-5 per cent body oxygen intake. K. Agner (*ibid.*, suppl. 8, 1941) isolates a new iron containing "verdoperoxidase" from leukocytes, which is responsible for the green color of chloroleukemic infiltrates.

4. *Odds and Ends:* J. Gillman (S. Afr. J. Med. Sci., 6:59, 1941) shows basal fat distribution in cells of endometrium is proportional to progesterone concentration (directly) and to estrone concentration (inversely) and may be used to estimate therapeutic effectiveness of progesterone. E. Chain, H. W. Florey and associates (Lancet, 241:177, 1941) give much detail on preparation, assay, low toxicity, rapid urinary excretion, and very high bacteriostatic action of "penicillin." G. Lockemann, et al. (Zentralbl. Bak. Parasit. Infek., 147:1, 1941) in comparing germicidal action of methyl, ethyl, n-propyl, and iso-propyl alcohols find n-propyl alcohol most generally active over widest range of mixture with water.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Butte County Tries Group Doctoring

Oroville, November 10 (INS).—Individual health costs less than $1 a month on a coöperative basis in Butte County for 119 low-income farm families.

The Butte County farm family is the smallest of any county in the state, and has been selected as a model for the medical health coöperative by the Federal Security Administration.

Dr. William Reidy, FSA official of San Francisco, said the federal agency has loaned many of these families the necessary $48 a year to enter the coöperative.

Lowest in Price

Based on 3.9 members to the average family, the experiment is costing each participant less than $1 a month, he explained. Yet, the coöperative is the lowest in price and the most inclusive of medical service offered by any group in the nation.

Broken limbs, confinements, appendectomies, and innumerable illnesses which come suddenly and unexpectedly upon a family are furnished for the nominal yearly fee.

Backed by Doctors

Backed by the California Physicians' Service, each cooperative member can choose his own physician within the organization.

Similar experiments are being organized in the state, and California now has 260 low-income farm families under the coöperative plan.—San Francisco *Call-Bulletin*, November 10.

* * *

Medical Journal Flays Vitamin "Gold Rush"

Chicago, October 24 (UP).—Eat a balanced diet and forget "shotgun vitamin pills," *The Journal of the American Medical Association* advised today in an editorial effort to stem "the vitamin (pill) gold rush of 1941."

"There are lush profits in the vitamin business," the *Journal* said in its editorial. "Enterprising manufacturers of all kinds are climbing on the wagons and taking the trail . . . in a vitamin gold rush of 1941, making the California trek of 1848 pale by comparison."

The editorial criticized "the unwarranted claims" being made by manufacturers promoting the sale of vitamins to the public, and suggested:

"If daily consumption of a good serving of ham, a green vegetable, a glass of milk, a slice of brown bread, an orange, and other constituents of a suitable diet will not maintain the body in a proper state of nutrition, a medical study is needed more than a shotgun pill of vitamins."

The editorial said vitamins are essential as important food constituents, but that adding them to diet in "unlimited amounts" will not increase bodily efficiency or necessarily bring the "health and beauty" promised by some manufacturers.—Pasadena *Star-News*, October 24.

Use of Mineral Springs as Health Centers Advocated

Representatives of the medical profession, mineral springs resort owners, and the California State Chamber of Commerce met Sunday at Sobre Vista in the Valley of the Moon as the guests of Mrs. Alma Spreckels Awl and pledged themselves to making California the outstanding mineral springs health center of the United States.

It was the consensus of opinion that for too long this wonderful natural resource has been neglected.

It was brought out by many who are well acquainted with the mineral springs of Europe that California mineral springs in quantity and quality are equal to or superior to those of Europe. Further, that today there is a more urgent need of their development than at any time in history—for the general public under the strain of national defense and for the possible use of the Army and Navy and to assist in the President's plan of rehabilitation of thousands of rejected enlistees.

A committee of the medical profession will immediately begin a study of the mineral springs of California in conjunction with the State Chamber of Commerce. This study will include the number and kind of springs, a chemical analysis of the water accommodations at present and those needed, and many other factors.

Mrs. Awl, in her enthusiasm, offered to the group assembled, an outright gift of some eighty or more acres in the Sonoma Valley on which are five splendid mineral springs for a development comparable with the best springs of Europe.

Those attending the meeting included Mrs. Alma Spreckels Awl; Dr. Henry S. Rogers, President of the California State Medical Association; Dr. George H. Kress, Secretary of the California State Medical Association; Dr. Howard Morrow, Dr. George Reinle, Dr. Charles A. Dukes, Dr. O. D. Hamlin, Dr. J. C. Geiger, Dr. Leo Stanley, Dr. Julius Wolfson, Miss Margaret Copren, Dr. C. A. Walker, Dr. Andrew B. Stockton, Dr. Leo Eloesser; A. E. Goddard, Chairman of the Travel and Recreation Committee of the California State Chamber of Commerce; George Hoberg, Director of the California State Chamber of Commerce, Lake County; Joseph R. Knowland, Director of the California State Chamber of Commerce; Clarence Prather, Adams Springs; Lee Richardson, Richardson Springs; Jerry Carpenter, Travel and Recreation Committee of the California State Chamber of Commerce.—Santa Rosa *Republican*, October 21.

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City Owns Unique Medical Library

Pasadena has an excellent medical library in its health department which is open every day to the public. However, it is used very seldom by anyone except members of the department staff because few people know of its existence.

Tucked away in a quiet, airy room down the corridor of the wing which houses this vital department of the city, the library affords an opportunity for educatonal reading for those interested in medicine, bacteriology, dietetics or any other allied suhject. There are comfortable window seats cushioned with beautifully made pads fashioned by the women of the health department in their homes. This room is their pride, for here they can go in odd moments to brush up on their work.

Valuable Documents

Books by such famous scientists as Sir William Osler are to be found on its shelves. There are medical dictionaries, important pamphlets and laboratory reports.

The most recent and valuable addition to the library is the "Current List of Medical Literature," privately published on a nonprofit basis under the auspices of the Friends of the Army Medical Library, Washington, D. C., for the promotion of medical research. It permits scanning the contents of a far larger number of journals than most readers could spare time to examine. Everything of medical interest that is found in the more than 3,000 periodicals received by the Army Medical Library is recorded under forty-four classifications in this list. . . .—Pasadena *Independent*, Novemher 7.

* * *

Blood Bank Sets More Records

Number of Donors, Transfusions Increase

San Francisco County Medical Society's Blood Bank Commission announced yesterday that the nonprofit Irwin Memorial Blood Bank is keeping up with the tempo of the times by breaking its own records, month after month.

The nnmber of donors during October, the Commission reported, exceeded 500 for the first time since the blood bank was opened last June, with estimates that the number of transfusions sent to patients in hospitals during October also would surpass previous months.

Among the October donors, the Commission added, were many who came from other communities, while a numher were repeaters—persons who already had made at least one donation.

Month by month figures on the donors who give their blood that others may live were: June, 51; July, 276; August, 306; September, 433; and October, 506.

All healthy persons between the ages of 21 and 60 are eligible as donors, and those interested in contributing can make arrangements by telephoning WAlnut 5600.—San Francisco *Examiner*, November 3.

* * *

Second Medical Corps Speeded

Hopes that the second medical battalion of the California State Guard will be mustered into service next week rested today on the number of volunteers who enlist in the unit at the weekly drill tonight at the National Guard Armory, Fourteenth and Mission streets.

Twenty-four volunteers already have enlisted, but a minimum of thirty-four, or 60 per cent of a full complement, is required before the unit officially becomes part of the Guard, Lieutenant Maurice H. Auerbach declared. If the required number sign up tonight, the battalion will be mustered in next Friday, he said.

The unit's chief need is several young physicians. The one and one-half hour training period each Friday evening consists of one-half hour of military instruction and one hour of first aid and military medical training.

On induction of the unit, ambulances, stretchers, medical kits, and other equipment are supplied by the state.

Brigadier-General Sam Downing is in charge of the medical corps and surgeon-general of the California State Guard.

* * *

Kern County Hospital Raises Granted

Bakersfield, November 24. — Six physicians at Kern County General Hospital today received pay boosts totaling $575 by order of the County Board of Supervisors following recommendation of Dr. J. M. Kirby, new superintendent appointed by the Board of Supervisors to succeed Dr. Joe Smith.

The increases marked the first changes made at the $6,000,000 County Hospital since Doctor Kirby officially became superintendent at a salary of $15,000 a year.

Those Benefited

Doctor Kirby recommended jumping from $250 to $300 per month the salary of Dr. W. H. Eaton, assistant surgical resident.

Increases of $100 a month, from $150 to $250, were asked for four resident physicians—Dr. Aaron E. Oswald, Dr. Carl E. Willers, Dr. W. J. Waldman, and Dr. E. Earl Bricky.

Raise of $75

A boost of $75 a month, from $275 to $350, was requested for Lester S. Gale, resident venerealogist, who, according to Doctor Kirby, has agreed to take care of the women's medical ward in addition to his venereal disease work.

Salaries of $400 a month for Dr. D. S. Lambeth, chief resident physician, and Dr. Gilbert H. Jonson, radiologist, were left unchanged.

The new superintendent had informed Supervisors salary increases would be necessary if present staff physicians and surgeons were to be expected to remain at Kern General Hospital and not accept more lucrative jobs elsewhere.—Los Angeles *Times*, November 25.

* * *

My Day

By Eleanor Roosevelt

Health Coöperative

Talking of health, a most interesting health coöperative came to my attention the other day. It is called the New York Volunteer Health Coöperative. You have a certain freedom in the choice of doctors. You pay $18 a year without hospitalization. You cannot belong if you earn more than $2,000 a year while single, or $3,000 a year when married. There are already over one thousand members.

There is much I should like to find out about this organization. For instance, just what are the services rendered if hospitalization is not included? I suppose if there is only a limited choice of doctors, there will be the same complaint about the doctor-patient relationship. People in this salary range do need more access to good and inexpensive medical care.—E. R., in San Francisco *News*.

* * *

Praise Is Given Hospital, Services of Medical Men

Editor of The Bee—Sir: Recently I have read several letters from mothers and now one from A Father complain-

ing about the high prices doctors and hospitals charge. One letter alone, perhaps I missed some, praised the doctors, etc.

Well, I am neither a nurse nor a doctor nor do I run a hospital. But I do praise our doctors, as a whole, and our two large hospitals. They do not overcharge. In most cases the doctors work many long hours, night and day, and have very little home life or recreation. Too, in most instances, the doctor is the last person to receive his pay; if he gets it all, he is very lucky.

I think A Father was extremely fortunate if the cost was only $85 for eleven days. His wife probably had the best care; and if she and the baby are healthy that should be his main concern. After all, I believe he may pay the $85 in installments, if he has not the cash.

As for the hospitals, they are not too high. Yes, I can say this honestly, for I have been bedridden for many years. I have a wonderful husband, an adoring family. All are wonderful to me and I love being home. But if our income would stretch I would gladly go to the hospital again and remain as long as I could. I really believe that with the expert nursing, the best food one receives, under strict supervision and no worrying about laundry, cleaning, etc., even I could get well.

People go to a fine hotel, getting good service, of course, but is someone at your beck and call every moment? Are your meals included and served you in bed at anywhere near the price as at a good hospital? I do not mean to convey the idea that hotel rates are too high. I am just comparing. I mention Sacramento's two hospitals only because I have been a patient in them both many times.

It has been very hard for us to scrape up the money, but that is not because the doctors or hospitals charge too much. I should like to see the average layman perform the long hours of hard work doctors and nurses do and have as little time for their own enjoyment. They would give up. Doctors never give up, night or day. And most doctors, when they do take a few days, go back to medical college to learn more and better ways of easing our suffering. And then people complain that they charge too much.

Any skeptic who thinks this was written with an ulterior motive may have my name and address from *The Bee*. Mrs. H. T., Sacramento.—Sacramento *Bee*, October 23.

* * *

Labor Problems in Hospitals Are Aired at Confab

Hospital personnel problems and ethics were reviewed by Dr. Benjamin W. Black, junior past president of the American Hospital Association, in one of the featured addresses of the mid-year meeting of the Association of California Hospitals in session in The Californian.

Doctor Black told the 150 delegates stringent regulations covering all phases of hospital operations should be established and all employees should be properly acquainted with the rules.

State Attorney Is Speaker

Other speakers today included Kathryn Flanagan, attorney for the State Division of Industrial Welfare; Alice G. Henninger, superintendent of the Pasadena Huntington Memorial Hospital; Paul Elliott, superintendent of the Hollywood Presbyterian Hospital; Bertram P. Brown, director of the State Department of Public Health; Howard Burrell, attorney for the Association; and Dr. George H. Kress, secretary of the California Medical Association, who discussed the proposed Basic Science Initiative.

Several discussion panels were conducted throughout the day and will continue tomorrow.

The program will open tomorrow at 8 a. m. with a breakfast, to be followed by a general session on nursing problems. Following several round-table discussions, the two-day program will end at 3:30 p. m.—Fresno *Bee*, November 8.

* * *

Supervisors Study Request for Funds for Medical Library

The Fresno County Board of Supervisors late yesterday took under advisement the request of Dr. Dwight H. Trowbridge, librarian for the Fresno County Medical Society, for county assistance in the operation of a medical library for the benefit of the society.

The Supervisors took no action on a suggestion that a library could be housed in the former Dearing Home on Fresno Street, directly opposite the Burnett Sanitarium, saying there might be some inference of discrimination in favor of that hospital.

Board members said no county action can be taken before the next fiscal year. Supervisor Terrill C. Efird suggested the library might be located in the County General Hospital, but Doctor Trowbridge said there is some objection to that plan because not all doctors are members of the county hospital staff.

He suggested a library by which medical journals could be mailed to doctors residing long distances from Fresno, if they are unable to personally visit the library.

Trowbridge estimated at $300 a year the minimum which would be required from the county. He said librarian and possibly custodial aid would be needed.—Fresno *Bee*, November 15.

* * *

Army Doctors Examine Men Under New System

Uncle Sam's streamlined induction service conducted by Major Alberto E. Merrill at 406 South Main Street, continued to function yesterday with 202 possible selectees for Army training reporting for physical examination.

Under the new system the selectees report for examination several weeks before their induction date, and the Army doctors, whose report determines whether the selectee is fit for active service, complete their record before the induction date.

Under the old system, many selectees passed by their draft board physicians were rejected by the Army doctors on the day of induction.—Los Angeles *Times*, November 26.

* * *

Radiological Society of North America

Meets in San Francisco

The San Francisco Medical Society today was preparing to welcome six hundred radium and x-ray specialists from cities of North and South America due here Monday morning for the annual convention of the Radiological Society of North America.

Dr. Harold A. Fletcher, President of the County Medical Society, will greet the delegates at the opening session in the Fairmont Hotel.

As another feature of the convention, Dr. L. Henry Garland of San Francisco, former chairman of the American College of Radiology, will conduct a symposium on the diagnosis of fungous infections.

Tuesday evening the radiologists and the County Medical Society will be addressed by Professor W. Edward Chamberlain of Temple University, Philadelphia, on "The Rôle of Fluoroscopy in Medicine."

Scientific sessions will be held continuously throughout the week. Scientific exhibits illustrating recent advances in x-ray diagnosis and treatment and radium treatment, will be on display.—San Francisco *Call-Bulletin*, November 28.

LETTERS†

Concerning an Opinion from the Attorney-General on Exemption of Dues of California Licentiates in Military Service of a Foreign Power.

(COPY)

STATE OF CALIFORNIA
LEGAL DEPARTMENT

San Francisco, November 6, 1941.

Board of Medical Examiners
1020 N Street
Sacramento, California
Attention: Charles B. Pinkham, M. D.
Secretary-Treasurer

Gentlemen:

This is in reply to your letter dated October 20, 1941, and forwarded to this office by the Director of the Department of Professional and Vocational Standards under date of October 28, 1941, in which you request our opinion "as to whether the provisions of Chapter 21, Statutes 1941 are applicable to a licentiate who serves with a foreign power."

The pertinent provisions of the statute to which you refer read as follows:

Every person licensed under this chapter is exempt from the payment of the annual tax and registration fee in any one of the following instances:

(*a*) While engaged in full-time active service in the

† CALIFORNIA AND WESTERN MEDICINE does not hold itself responsible for views expressed in articles or letters when signed by the author.

medical corps of the Army, Navy or Marines or in the United States Public Health Service.

(*b*) While fulfilling his full-time period of training and active service, whether as a draftee or volunteer, under the Selective Training and Service Act of 1940 and any amendments or additions thereto or acts supplementary thereof.

Clearly, one serving with the forces of a foreign power does not come within subdivision (*a*) above.

With respect to subdivision (*b*) *supra*, examination of the Selective Training and Service Act of 1940 (54 Stats. Chap. 720, p. 885), discloses no reference to persons serving in the forces of a foreign power. Consequently, such a person would not be exempt under said subdivision.

It seems clear, therefore, that the legislature intended to exempt from the payment of the annual tax and registration fee only such licensees of your Board as are engaged in the services of this country enumerated as above.

The intent of the statute being clear, it is not for administrative bodies or for the courts to add thereto.

Estate of McDonald, 118 Cal. 277, at 280;
Frinier vs. *G. J. Kubach Co.*, 177 Cal. 722, at 727.

It is, therefore, my opinion that a licensee of your Board serving with a foreign power is not exempt from the payment of the annual tax and registration fee required by Business and Professions Code, Section 2450.

Very truly yours,

EARL WARREN, *Attorney-General.*
(Signed) Thomas Coakley, *Deputy.*

Letter Concerning the Late Howard Morrow, M. D.

(COPY)

A. H. GIANNINI, M. D.
LOS ANGELES, CALIFORNIA

November 4, 1941.

To the Editor:—It is now ten days since I learned of the death of Howard Morrow, but the sense of loss remains, and ever will remain, as poignant as on the day when, going aboard the Chief at Chicago, I was handed a telegram telling me of the shocking news. Although some of us knew that he had an unreliable heart, his passing, nevertheless, seems incredible, for how could one so vital, go so suddenly out of life?

Sadness must be expressed at his death, but greater sorrow is there that one preëminently a leader should be lost to his generation. Many saw in him those qualities which create a memorial for their possessor more lasting than any made by the hand of man. His ideals were high, his achievements were great.

All who came within the influence of his happy nature and personality, of his fine discrimination between right and wrong, of his enthusiasm for perfect fitness, of that especial regard he always paid to those whom he deemed less fortunate than himself, and of that insistent recognition he paid to good qualities in any men—knew the great, golden worth of Howard Morrow.

In duty he was inflexible, in pleasure he was warm, and the widespread company of those who mourn him, testify to the sunshine of a noble personality. He always had a very clear understanding of the tasks which duty demands and a resolute determination to carry out that duty wherever, whenever, and however it called upon him. Just as he had a love for right and justice, so, too, had he an abhorrence for wrongdoing and unfairness.

His high sense of loyalty throughout his career brought him many friends from all ranks. As a doctor he was venerated throughout the medical profession, as a teacher he was stimulating and sympathetic.

Around the doctors who guided the destiny of the Medical School of the University of California in its early beginnings, there glows a grandeur, and it is right to see in its light the personalities of those who contributed so much to kindle what has become an enduring flame.

Bright names rise in glad remembrance, names which it would be fine to hear, and good to mention—McLean, Kerr, Swan, Taylor, Montgomery, Von Hoffman, Lewitt, Williamson. To Howard Morrow was given the rare opportunity of personal communion with these men. We have always honored their memory not only for their great accomplishments, but also for having inspired and encouraged a group of younger men to carry on their work in the best medical tradition. Thus a new, vital and dynamic force was created. Conspicuous in this leadership were many of my fellow students, amongst whom was Doctor Morrow.

I saw them build to the eminence of success step by step. Theirs was a faultless record of accomplishment, and latterly the University of California Medical School became the beneficiary of their intellectual possessions. The Medical School was quick to see in Howard Morrow not only the doctor and teacher, but the man of good will—kindly, democratic, able, and with the gift of charm and intimacy to suffuse his classroom.

Of all the splendid service rendered to the Medical School of the University of California, none was more effective and none rings more sturdily down the years than the devotion and ability of Doctor Morrow. His direct contribution to medical knowledge was indeed important, but equally valuable was his indirect contribution through the students he inspired and encouraged, and the standards of ethical practice which he set down for them.

He was especially happy when he could give tirelessly of his knowledge to any newcomer seeking a medical education. To have been in a position to help others sustained him immeasurably during his last years. Courage, fairness, love of sports, kindness, loyalty—these words come to mind when thinking of him. We, who have been so frequently his messmates, will miss him oh, so very, very much. No greater tribute can we give him than to say how hollowly we feel an absence where once so lately dwelt such a massive and compelling presence.

I am pleased to learn that Howard's son, Grant, is an up and coming young doctor. His is a fine heritage. His dear father's tradition will be safe in his keeping.

Yours sincerely,
A. H. GIANNINI.

Concerning an Insurance Fakir: Warning.

November 24, 1941.

To the Editor:—On November 1, last, a man representing himself as Mr. Verlie H. Tompkins of the Union Life Insurance Company of Little Rock, Arkansas, appeared at my office with the following story:

That his insurance company, formerly confining its activities to Arkansas, was opening a western division. That I had been recommended as medical examiner for Redlands. And that it was customary to write some life insurance for the medical examiner.

I gave Mr. Tompkins my check for $84.02 The Union Life Insurance Company now writes me that Mr. Tompkins is not an agent of their company, and that they do not do business in California.

Mr. Tompkins is of medium dark complexion, about 6 feet 3 inches tall and very slim, about 140 pounds. He was wearing a brown suit, and spoke with an Arkansas accent. He was provided with credentials and supplies of stationery of the Union Life Insurance Company, including application and examination forms.

I am writing to you in the hope of saving other California physicians from a similar experience, and in the further hope of apprehending this man. I shall have a warrant issued for his arrest.

Yours very truly,
(Signed) ————————, M. D.

MEDICAL JURISPRUDENCE†

By Hartley F. Peart, Esq.
San Francisco

Malpractice: Qualification of Expert Witnesses

In actions against a physician for malpractice, it is thoroughly settled in California that the physician, in prescribing for or treating the patient, is bound to exercise only that degree of medical skill and care ordinarily possessed and exercised by physicians and surgeons practicing in the same locality or community. He is not held to the highest degree of skill known to the medical profession. Accordingly, whether the defendant physician has met the required standard and prescribed a course of treatment such as under like circumstances would have been prescribed by the average physician practicing in the community, becomes the principal and determinative issue in the majority of malpractice cases. It is equally well settled that the establishment of the standard by which to judge the actions of the defendant physician is properly the subject of expert testimony and, in fact, may only be established by the testimony of competent experts. The question then, as to who will be permitted to testify in favor of the plaintiff, is of utmost importance to the physician who finds himself confronted with a charge of malpractice.

A number of rules have developed governing the selection of expert witnesses in malpractice cases, but they offer a wide field from which plaintiff may choose. To qualify as an expert in a malpractice case a witness must show himself to possess learning and knowledge in the particular subject under inquiry sufficient to qualify him to speak with authority thereon; in addition, he must demonstrate a familiarity with the treatment and degree of care and skill of practitioners in the locality sufficient to qualify him to express an opinion on this question: Was the defendant's treatment consistent with that which other physicians in the exercise of reasonable care might do in similar circumstances?

In a very recent decision of the California District Court of Appeal, *Sales* vs. *Bacigalupi* (October, 1941), 47 A. C. A. 87, recovery in a malpractice action depended on whether the defendant physician had exercised the requisite care and proficiency in treating the plaintiff for an infection developing from a nail in plaintiff's shoe which had pierced the sole of her foot. The defendant physician after examining plaintiff had prescribed a wet heat treatment for the foot and had continued this treatment after a second examination. It ultimately became necessary to amputate a part of the leg and plaintiff then commenced suit for malpractice, contending that when the defendant first examined her it was apparent that she was suffering from a local abscess which required immediate incision rather than the wet heat treatment which defendant had prescribed and administered.

A number of witnesses for the defendant, including the physicians who had amputated the leg, testified with a fair degree of unanimity that there had been no local abscess, but only a general infection, for which the defendant had prescribed the customary treatment. Opposed to the medical testimony for the defendant was the testimony of an Oakland physician (Doctor Ruedy) who, in answer to a long hypothetical question embodying an entire history of the case from the original injury to the amputation, testified that at the time of the defendant's first examination of the plaintiff there was an abscess present and that in the exercise of that degree of care and skill ordinarily possessed and exercised by physicians and surgeons in San Francisco "The only method of choice was the prompt opening of the primary point of infection, draining the point of infection under antiseptic methods, and by local anesthesia."

The trial court gave judgment for the plaintiff and on appeal the judgment was affirmed, the District Court of Appeal saying:

> Doctor Ruedy's testimony created a conflict in the evidence and is sufficient to support the verdict. The testimony of a medical witness in answer to a hypothetical question based on the facts in the record is sufficient to support a finding contrary to the testimony of other medical witnesses who have seen and examined the patient. (Citing authorities.) Nor can the fact that Doctor Ruedy's testimony conflicted with all the other medical testimony affect this rule since the testimony of one credible witness, if believed by the jury, is sufficient to support a verdict.

The introduction of this witness' testimony was objected to on the ground that the injury had occurred in San Francisco and that, therefore, an Oakland physician did not have the requisite knowledge of the degree of care and skill ordinarily exercised in the community. The court held that, in view of the close proximity of the two cities and the metropolitan character of the entire area, the witness was sufficiently qualified. This decision is in accordance with previous decisions of the California courts since it has been decided that a physician or surgeon who is qualified to testify as to the degree of care and skill possessed by the average practitioner in Los Angeles is also qualified to give an expert opinion upon a question of medical procedure of a physician whose practice is confined to the city of Pasadena (*Warnock* vs. *Kraft,* 30 C. A. (2d) 1), and in another case that a Los Angeles physician was qualified to testify as to the standard of care exercised by physicians in Long Beach. These decisions, however, should not be interpreted to allow a doctor from one community to be transported to all parts of the state as a witness when he has never practiced in the locality in which he is to testify and knows nothing of the quality and methods of its medical profession. The test should be knowledge of methods in the same community and not knowledge of methods in communities of the same size or in urban as opposed to rural areas. Accordingly, it was held in *Bickford* vs. *Lawson,* 27 C. A. (2d) 416, that a doctor practicing in Arbuckle, California, was not competent to testify as to methods of treating leg fractures in Willows, California, thirty-five miles from Arbuckle, when it was not shown that he had any knowledge of the customary methods of treatment employed by members of the medical profession in Willows.

In the language of the court in the *Sales* case, above quoted, it was pointed out that the testimony of one "*credible* witness" is sufficient to support a verdict in favor of the plaintiff. Counsel for the defendant attempted to introduce evidence attacking the credibility of plaintiff's witness. The witness was asked on cross-examination if during prohibition his federal license to prescribe liquors was not revoked. On receiving a negative answer, defendant then attempted to introduce a certified copy of an order revoking his license. This was improper and inadmissible, as a witness, with the exception of conviction of a felony, may not be impeached or discredited by evidence of particular wrongful acts. The manner in which a witness may be impeached or discredited is specifically provided in California Code of Civil Procedure, Section 2051, and includes "contradictory evidence or by evidence that his general reputation for truth, honesty, or integrity is bad." In the vast majority of malpractice cases, contradictory testimony by expert witnesses is introduced by the defendant to overcome that given by witnesses for the plaintiff, but litigants in these cases should not overlook the possibility of introducing evidence that the general reputation for truth and honesty in the community of the other side's witness is bad if, in fact, such is the case.

† Editor's Note.—This department of California and Western Medicine, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL

Vol. XIV, No. 12, December, 1916

EXCERPTS FROM EDITORIAL NOTES

Malpractice Indemnity Fund.—Are you one of the 2,220 members of the Society who have intended to contribute to the Fund, or are going to do so, or are thinking about it but have not done so? If you are one of this class, you had better send your check for $15 and your note for like amount, payable one year after date, immediately.

Indemnity Fund.—The correspondence which has developed since the announcement of the creation of the Malpractice Indemnity Fund has been very voluminous. Practically without exception, everyone who has written to the secretary has approved the plan.

One man writes as follows: "Happy is the man that has never been sued or threatened with a suit, but the fateful day may come to any physician, and we had better all stand together to take care of ourselves when we have such a good chance as now is offered." . . .

Again the Indemnity Fund.—A member who transmits his check and note as a contribution to this fund, raises the question as to whether there would be any objection to a member also carrying insurance, and whether it would be of any value. There certainly can be no objection. It would be of value only to this extent, that it would conserve the Fund; because, firstly, if such a member was sued, the insurance company would have to bear the expenses of the suit, though our attorneys might coöperate in the actual trial if it were necessary; secondly, if a judgment went against the member the insurance company would have to pay up to the amount of the policy, thus conserving the fund of our own members in our own hands.

Needed Reform of County Societies.— . . . There has never been in the history of the State Society a more imperative need for the effective organization and consolidation of the mass of the profession than at the present time. But the State Society labors under a serious disadvantage in so far as its strength is the collective strength of its component county societies. These as the ultimate units must develop greater force and effectiveness in order to aid the State organization, if it is to secure a just regard for the reasonable demands of its members whether before the general public or its representatives. . . .

. . . To remedy this deficiency the policy of a county society must extend beyond the scientific program and the library, however attractive. The county society should encourage a spirit of free association among its members. It should formulate plans tending to increase sociability and provide facilities having this end in view. Societies have been too indifferent in the matter of securing new and desirable members, and they should make every effort to increase membership. Above all, they need leaders of clear insight and in close sympathy with the body of the profession and the movements that affect it, men of marked executive ability whose utterances and unstinted, disinterested activities command attention, respect and confidence, while they carry conviction and actuate others.

(Continued in Front Advertising Section, Page 12)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By Charles B. Pinkham, M. D.
Secretary-Treasurer

Board Proceedings

At a regular meeting of the Board of Medical Examiners held at the State Capitol, Sacramento, October 20 to 23, 1941, there were seventy-eight applicants for written examination of all classes, including those graduates of foreign medical schools exempted under Chapter 751, Statutes 1941.

The legal calendar consisted of fourteen licentiates who had been called before the Board, charged with unprofessional conduct.

The following changes were made in the status of licentiates:

Oliver Roy Busch, M. D., Oakland, found guilty and on October 22, 1941, license was suspended for a period of one year from November 1, 1941.

Howard D. Mayers, M. D., Fall River Mills, charged with habitual intemperance, license was revoked on October 22, 1941.

Frederick William Riley, M. D., Los Gatos, charged with aiding and abetting an unlicensed individual, *i. e.*, William F. Hoque, who operated the Valley Rest Home, Los Gatos, where patients were treated with an escharotic paste in an asserted "cure" of cancer, license was revoked on October 23, 1941.

The probationary period of Henry Gross, naturopath, imposed on July 12, 1939, was terminated on October 23, 1941.

The probationary period of Edith M. Stoker, imposed on June 26, 1940, was terminated on October 20, 1941.

The certificate of Oscar Charles Long, revoked on March 10, 1938, was on October 21, 1941, restored and he was placed on five years' probation without narcotic privileges and to report at each Los Angeles meeting.

* * *

Dr. Clark L. Abbott of Oakland was reëlected president; Dr. Fred R. DeLappe of Modesto was elected vice-president; and Dr. Charles B. Pinkham was reëlected secretary-treasurer.

News

"His appeal which he carried to the United States Supreme Court having been denied, Dr. Nathan S. Housman of San Francisco, entered San Quentin yesterday, became No. 67,441 and started serving a one to fourteen-year term for perjury which grew out of narcotics violations. Thus, after a fashion, the slim, immaculate physician rejoined his pal, former San Francisco Public Defender Frank J. Egan, now serving a life term for the slaying of Mrs. Jessie Scott Hughes, elderly widow. Egan had used the doctor as an 'alibi' during the murder trial. Doctor Housman is alleged to have given perjured testimony during his first trial on misdemeanor charges of failing to keep proper records of narcotics prescriptions. Now a convicted felon, he faces loss of his physician's license." (Oakland *Tribune*, November 5, 1941.)

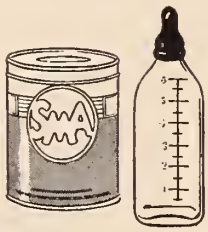
"A new trial for Dr. William Walter Reich, Berkeley physician charged with four counts of illegal voting, was set today for December 1 by Superior Judge Edward J. Tyrrell. Doctor Reich has maintained that he is an Ameri-

(Continued in Back Advertising Section, Page 28)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6. News Items are submitted by the Secretary of the Board.

The answer
To Your Infant Feeding Problem!

THIS IS WHAT S-M-A IS . .



A scientifically prepared formula for infants deprived of breast milk.

THIS IS HOW IT IS PREPARED . . . . . .

1. Empty one tightly packed measuring cup of S-M-A Powder into bottle.

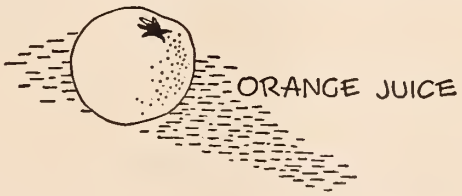
2. Add enough warm, previously boiled water to make one ounce.

3. Cap bottle and shake into solution. Feed at body temperature.

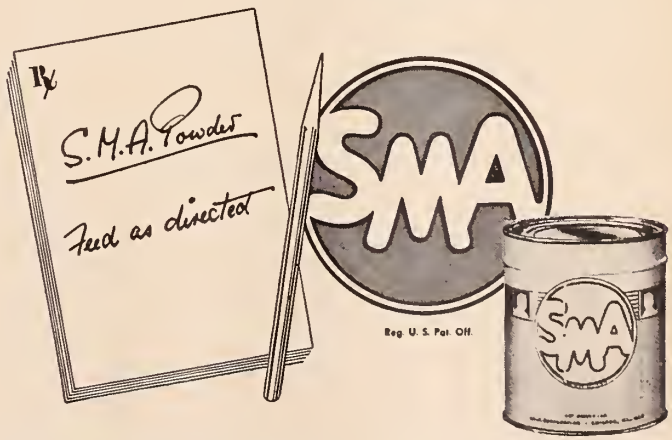
THIS IS THE WAY IT IS FED

The quantity and number of feedings in 24 hours should be the same as that taken by the normal breast-fed infant.

THIS IS THE ONLY SUPPLEMENT REQUIRED . .



AND THIS (in a nutshell) is the Easy, Economical Way used by an ever-increasing number of physicians to insure excellent nutritional results.



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(Continued from Front Advertising Section, Page 24)

The foregoing information is furnished as it is believed it is of interest to you, and that you will want to give it some notice in your journal. Very truly yours, W. C. Braisted, Surgeon-General, U. S. Navy.

From Item: "Abstract—Sanitary Units in the Field and Lines of Medical Aid," by Captain Leo C. Mudd, Medical Corps, United States Army.—In the Zone of Advance (year 1916), that is, within or immediately adjacent to the field of fighting, there is found, typically, the following:

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BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 336)

can citizen, while the prosecution contends that he was born in Singapore. A first trial ended in a disagreement by the jury." (Oakland *Tribune*, November 4, 1941.)

(Continued on Page 30)

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 28)

"Dr. Adam Paterson, prominent local physician and clubman, will leave by plane from the Oakland airport next Tuesday morning bound for Vancouver, B. C., where he will enlist in the Royal Army Medical Corps for war duty overseas. He will board a United Airliner at 2:30 a. m. headed for Seattle, Washington, where he will change to another plane for Vancouver, he said." (San Leandro *News,* October 31, 1941.)

Attorney-General Warren recently rendered an opinion that service with a foreign country does not exempt licentiates from payment of annual registration.

"Municipal Judge A. H. Stetson of Redwood City yesterday ordered Florence Hunter Williams, sixty-two, held for Superior Court trial on charges of performing an illegal operation. Bail was set at $2,500 cash." (San Francisco *Chronicle,* October 29, 1941.)

"Dr. Thomas D. Wyatt of Redding was reprimanded Wednesday by the State Board of Medical Examiners in Sacramento for violation of probation, but terms of his probation were left unchanged. Doctor Wyatt, whose license was suspended for a year on charges of abortion, was reissued his license and put on probation last October. On July 11, 1941, he was convicted in Redding justice court on a charge of violating the State Pharmacy Act by allowing a person other than a registered pharmacist to sell ant poison in his drug store here. He offered no defense Wednesday before the Medical Board, which sought to

(Continued on Page 34)

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1936. Mass. Agr. Expt. Sta. Bull. No. 338.

1937. Chemistry of Food and Nutrition, Fifth Edition, H. C. Sherman, MacMillan, N. Y.

1938. Nutrition Abstracts and Reviews 8, 281.

1939. Food and Life Yearbook of Agriculture, U. S. Dept. Agr., U. S. Government Printing Office, Washington, D. C.

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*J.A.M.A., Vol. 93, No. 15, p. 1110, Oct. 12, 1929
Bruckner, Die Biochemie des Tabaks, 1936
**The Military Surgeon, Vol. 89, No. 1, p. 7, July, 1941

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 30)

determine whether the violation should result in revocation of his license." (Redding *Record*, October 22, 1941.)

"Dr. Lee A. Stone, Madera City and County Health Officer, today recived his physician's and surgeon's certificate to practice in California, the certificate having been issued on October 20. He was among the group of out-of-state physicians and surgeons who took the California examinations of October 1." (Madera *Mercury*, October 22, 1941.)

"Judge R. L. Reid sentenced Temple L. Turner to pay a $250 fine and placed him on two years' probation yesterday in justice court after Turner had been convicted of violating the state medical code in a four-day trial last week. Full terms of the sentence included payment by Turner of $150 to Mrs. Ramona Leach, who testified she paid $300 for a 'cancer treatment' when Turner conducted his illegal practice at 463 East Olive Avenue. He was forbidden to practice any of the 'healing arts' for two years while on probation. He was given a choice of paying the $250 fine or spending 125 days in jail. . . ." (Burbank *Review*, October 16, 1941.)

"Dr. M. M. Maidman, forty-two, Hollywood physician, and Nicholas Francisco Sternheim de Leon, thirty two, of Honduras, were given six months' suspended jail sentences and fined $100 each by Municipal Judge Harold B. Landreth yesterday after they pleaded guilty to narcotics charges." (Los Angeles *Examiner*, October 21, 1941.)

(Continued on Page 36)

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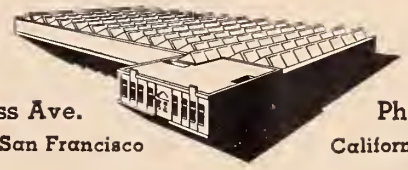

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 34)

"A. W. Zimmerman, local chiropractor, today filed a $50,000 damage suit charging malicious prosecution against W. Franklin Morris, secretary of the State Board of Chiropractic Examiners, and several other defendants. Zimmerman alleges that unfounded legal action against him resulted in his license being suspended." (Oakland *Tribune*, October 17, 1941.)

"John Palermo, 69-year-old former barber of 39 Little Orchard Street, will appear before Justice Grandin H. Miller October 20 at 4 p. m. to hear report on his application for probation on a conviction of practicing medicine without a license. He was found guilty of the charge brought by T. P. Hunter of the Board of Medical Examiners yesterday. . . ." (San Jose *News*, October 10, 1941.)

"Police arrested Clifford L. Pickett, 1449 East Fifty-fourth Street, last week and booked him on suspicion of murder after Mrs. Oretha Fields, 27-year-old housewife of 9501 Pace Avenue died as the result of an illegal operation. The woman passed away on September 28. . . . When Pickett was called to the stand by the Deputy Coroner, he declined to testify. . . . Dr. A. J. Linderman, General Hospital attaché, testified that the deceased had entered the hospital on June 1, suffering from an incomplete abortion. . . ." (Los Angeles *Eagle*, October 9, 1941.)

(Continued on Page 38)

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 36)

"Sensational charges of second degree murder and abortion were thrown at Dr. Walter R. Amlin, chiropractor, in an arraignment before Justice of the Peace William E. Fox Saturday noon. Bail was set at $25,000 and a preliminary hearing scheduled for 10 a. m. Thursday in justice court. Charges against Doctor Amlin are based on an alleged illegal operation, said to have been performed on September 6 at the chiropractor's offices, 30 North Raymond Avenue, on Mrs. Louistine Olga Bowers, twenty-two, of 96 Waverly Drive. Mrs. Bowers died on September 29 in General Hospital, to which she had gone on September 14." (Los Angeles *Eagle*, October 9, 1941.)

"Preliminary hearing of Dr. Edmund Marineau, thirty-eight, Hollywood physician, and his nurse, Miss Mabel Wilson Vremsak, thirty-seven, on abortion charges, was continued by Municipal Judge Byron Walters until November 14. The continuance was granted at request of the district attorney's office because a state witness is ill." (Los Angeles *Herald-Express*, October 11, 1941.)

"St. Louis Estes, health food lecturer, must pay his fine of $2,500 and serve 150 days in jail, for his conviction on ten counts of practicing medicine without a license. In a ruling handed down by the three judge appellate department of the local superior court, that judgment was affirmed without comment yesterday by Judges Franklin A. Griffin, Thomas Foley, and Robert McWilliams. Estes was convicted by a jury following a trial in September of 1940 before Municipal Judge J. E. White, but took an appeal from the conviction. Estes has been free on bail pending the appellate court decision." (San Francisco *Examiner*, November 1, 1941.)

"Slip of the Tongue" and Mental Disease Not Related.—"The answer to the question of why intelligent, well-educated people misplace words would involve a long philosophic discussion of what are considered in the Freudian literature as 'slips of the tongue,'" *Hygeia, The Health Magazine* states in a recent issue in answer to an inquiry as to whether such "slips" are a remote sign of insanity. "There are many different types of slips," *Hygeia* says, "some having rather obvious meanings, while others are obscure and little understood. Such 'slips' or the misplacement of words are common and bear no established relation to mental disease."

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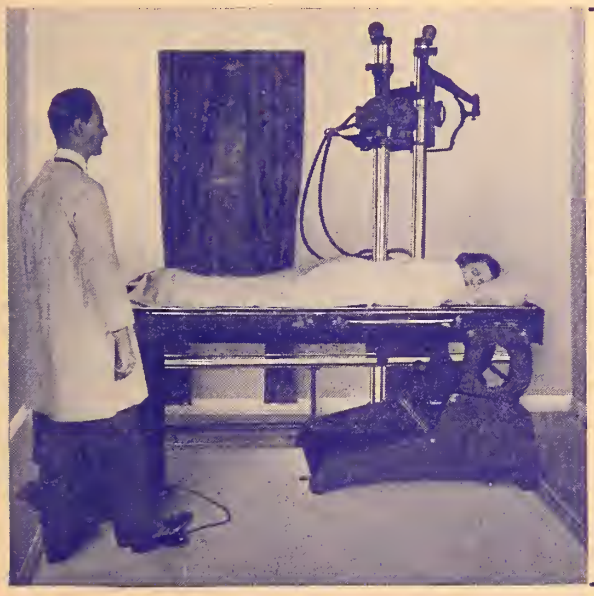

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*Treatment of Menstrual Disorders With Pregnant Mares' Serum, *William H. Vogt, Jr.* and *Daniel L. Sexton*, A.J. of Obs. & Gyn., 42:1

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